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

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Inspection de sions 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
Apr 4, 5, 2016	2016_284545_0008	005827-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE NEW ORCHARD LODGE
99 NEW ORCHARD AVENUE OTTAWA ON K2B 5E6

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

ANGELE ALBERT-RITCHIE (545), AMANDA NIXON (148), ANANDRAJ NATARAJAN (573)

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): March 14, 15, 16, 17, 18, 21, 22 and 23, 2016

The following complaint and critical incident were inspected as part of the Resident Quality Inspection:
Log #: 004615 related to a complaint regarding nursing and personal support services of a resident as well as dietary services and hydration
Log #: 032551 related to a critical incident the home submitted regarding allegations of abuse to a resident

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager, Resident Program Manager, Support Services Manager, Registered Nurses (RN), a Physiotherapist, RAI Coordinator, Wound Nurse Champion, Registered Practical Nurses (RPN), Personal Care Workers (PSW), Dietary Aids, Activity Aide, Housekeeping Aides, Restorative Care Aide, Physiotherapy Assistant, residents and family members.

The inspectors also conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, staff work routines and schedules, observed resident rooms, observed resident common areas, reviewed Residents' Council minutes, observed a medication pass, observed two meal services, and observed the delivery of resident care and services, including resident-staff interactions.

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
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

- **12 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care; such as catheter care to resident #035.

Resident #035 was admitted on a specified date in March 2011 with several medical conditions. According to the most recent assessment, the resident had an indwelling catheter and had occasional episodes of incontinence of urine.

On March 15, 2016 Inspector #545 observed resident #545 in bed; a large catheter bag in a pillow case was set on the floor by the bed and a small amount of dark amber colored urine was observed, as well as a lingering offensive odor. The odor was observed again, on March 16, 17 and 18, 2016.

The physician's orders were reviewed by Inspector #545, it was documented that an indwelling catheter of a specific size be changed every 4 weeks and to irrigate the catheter if the resident became distressed, or change if close to the change date.

In a progress note on a specified date in March 2016, it was documented that the indwelling catheter of a specific size was changed due to leakage.

A lab result from a urine sample collected two days following the change of catheter revealed three organisms isolated of mixed bacteria. Contamination was suggested and a repeat urine sample was recommended.

In a review of resident #035's most recent plan of care, it was documented that the resident required an indwelling catheter which put the resident at increased risk for urinary tract infection, and that the resident wore a brief in case the catheter leaked. Documented interventions included:
-to change the catheter as per physician's order
-identify root cause of leaking catheter and develop strategies to address issue
-use of brief
-maintain patency of catheter tubing and drainage bag placement; see Extendicare's policy and procedures regarding catheter bag maintenance
-monitor quantity, colour and consistency of urine and report irregularities such as dark colour, clarity and odor to registered staff promptly

During an interview with PSW #119 on March 18, 2016, she indicated that she had provided care to the resident earlier in the day. She indicated that a leg bag was not used as the resident did not like it and that the resident's legs were too edematous. She further indicated that the catheter bag was emptied at the end of her shift, then cleaned. The PSW described the catheter bag cleaning procedure as followed: disconnected the catheter bag and tubing, inserted water and vinegar, mixed in the bag by swishing around, then re-connection of bag to the tubing. PSW #119 indicated that she had not noticed leakage and/or odor.

PSW #124 indicated to the Inspector on March 21, 2016 that resident #035's indwelling catheter bag required cleaning two to three times per week and that a leg bag was not used. By demonstration, the PSW first emptied the catheter bag, then through the spout, inserted a small amount of water and soap mix into the bag. She indicated that the resident's urine could easily fluctuate in the day between clear and cloudy, with sediments. She further indicated that she changed the catheter bag whenever she noticed it to be soiled.

In discussion with RN #100, the RN indicated to the Inspector that the resident's indwelling catheter was scheduled to be changed every four weeks but was changed more frequently due to leakage, and confirmed that it had been changed on a specified date in March 2016 due to leakage. The RN indicated that due to high risk of infection, the physician had requested that a leg bag not be used, to prevent the opening of the

catheter bag system. She further indicated PSWs should not be disconnecting the catheter bag for cleaning as the bag was changed weekly by registered staff.

The Director of Care indicated to the Inspector that the PSWs were expected to empty resident #035's catheter bag once per shift, and apply a brief due to catheter leakage. She added that the catheter was often changed before the scheduled date due to leakage. The DOC further indicated that the physician recommended that the catheter system not be opened due to this resident's high risk of infection, and for this reason a leg bag was not used. The DOC indicated that Extendicare's Catheter Care Maintenance's policy was being revised, and in the meantime staff were to use Lippincott's "Best Practices in Urinary Catheter Care", however this best practice was not clearly defined for resident #035's specific needs, such as who was responsible of changing the catheter bag, the frequency of the catheter bag change and to not open the catheter bag for daily cleaning to decrease risk of infection. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #039's so that their transfer assessments was integrated, consistent with and complemented each other.

During an interview with the resident it was indicated that he/she did not participate in the choice of when and how to bathe. The resident indicated to the Inspector that staff provided he/she with a bed bath, and was told by some staff that it was not safe to provide the resident with a shower because of resident's physical limb impairment.

Resident #039 was admitted to the home on a specified date in November 2015 several medical conditions, including diabetes and a physical limb impairment. On a specified date in December 2015, the resident's condition deteriorated, and post hospitalization returned to the home with a specified type of care. According to the most recent restorative care assessment, despite a physical limb impairment, the resident had good trunk stability, was able to roll on right and left side, had good ability to maintain sitting balance in chair, and was able to follow instructions and was cooperative.

In a progress note dated a specified date in March 2016 it was indicated that the family had requested that the resident be showered. The note indicated that the wounds were healing well, and that the restorative care staff was informed to provide teaching to the PSWs on how to safely transfer the resident to the shower chair.

Upon review of the resident's most recent plan of care it was documented that staff were

to provide a bed bath due to current skin status. It was also noted that the resident would be showered on two specific days weekly on the day shift and to apply a plastic bag over the wounds to keep the areas dry. Progress notes from December 2015 to March 2016 indicated that the wounds were healing well and that there was no signs and symptoms of infection.

The current Bath List indicated that resident #039 was bathed two specified days weekly on the day shift.

During an interview with PSW #115 on March 17, 2016 she indicated that the resident received a complete sponge bath in bed twice weekly due to a physical limb impairment. The PSW indicated that the physiotherapist had assessed the transfer to the shower chair the previous week using a mesh sling but due to poor support and risk of slipping out, this sling was not to be used. The PSW indicated that the resident would then be showered on evening shift, using the a specific sling and after drying overnight, this sling would then be available to the resident in the morning. PSW #115 further indicated that the information was communicated to the registered staff by herself in report on March 17, 2016.

During an interview with the Restorative Care staff #121, she indicated that she provided transfer training and support to the staff on on a specified unit in February, before the resident moved to this unit and that the shower was well tolerated, using a tilt shower chair. She further indicated that the PSWs on day shift were not comfortable with the transfer to a shower chair and chose to continue with twice weekly bed bath.

The physiotherapist indicated to the Inspector that she had assessed on a specified date in 2016, the transfer to a shower chair using a specified size mesh sling and determined that it was too big for this resident and unsafe to use. She then recommended that staff use instead the resident's specified sling, normally used for transfers from bed to chair and vice-versa, and change bath time from day to evening, this way the resident would be returned to bed after the shower and the sling would be hanged to dry until the next day. The physiotherapist indicated that she recommended that the specified sling remain in place under the resident during the shower to prevent skin shearing due to the resident's high risk for altered skin integrity, decreased trunk control and decreased ability to turn from side to side due to a physical limb impairment. She further indicated that the restorative care staff and the DOC were informed of this plan and agreed to change the resident's bath time from day to evening to accommodate the drying of the specified sling.

The restorative care staff later indicated that at the request of the DOC and Administrator, she provided training on March 17, 2016 to two evening PSWs in transferring resident #039 using a specified sling unto a tilt shower chair. She indicated that based on her assessment, the resident had good trunk control, was able to move from side to side with assistance of two staff as was able to follow instructions well. She further indicated that the specified sling was removed prior to the shower, then re-applied after the shower, therefore did not wet the sling, and allowing staff to shower on day shift if they choose to.

RN #100 indicated that she was not aware of the change in plan until she was informed by a PSW at report on March 17, 2016.

As such the restorative care staff and physiotherapy staff did not collaborate in assessing the resident's transfer needs related to the shower and did not communicate this plan to direct nursing care staff and the resident. [s. 6. (4) (a)]

3. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with each other.

Resident #032 was admitted to the home on a specified date in July 2015. Resident #032 had multiple diagnoses, including contractures. Inspector #573 reviewed resident lift and transfer assessment completed by the Restorative care staff for resident #032 on specified dates in October 2015 and January 2016. Both the lift and transfer assessments identified that resident #032 required two staff physical assistance for the transfers with sit to stand mechanical lift.

A review of resident #032's nursing post fall progress notes on a specified date in January 2016, indicated that the resident lost balance when a PSW was transferring the resident from bed to toilet commode.

Resident #032's nursing written plan of care for transfers and toileting at the time of incident and the current plan of care in effect was reviewed by the Inspector. For transfers and toileting, both indicated the resident required extensive assistance with one or two staff. It further indicated that staff were to provide weight bearing assistance during transfers. There was no indication of the need to use any type of mechanical lift

with the resident, such as the identified sit to stand lift.

Physiotherapy assessment documented in a progress note on a specified date in January 2016, for transfers indicated "Use sit to stand lift if resident is compliant. If the resident feels tired and non-compliant use maxi lift transfer"

On March 21, 2016, Inspector #573 spoke with PSW #126 who indicated resident #032 was transferred by two staff by using sit to stand mechanical lift.

On March 23, 2016, Inspector #573 spoke with the Director of Care (DOC) who indicated that Restorative care staff #121 was the lead for the home's lift and transfer assessment for all the residents in the home. Further the DOC agreed with Inspector #573 that resident #032's lift and transfer assessment was not integrated and updated in the written plan of care to reflect the resident's transfer status. [s. 6. (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 staff and others involved in the different aspects of care collaborate with each other in the transfer assessment of resident #032 and resident #039 so that their assessments, development and implementation of the plan of care are integrated and are consistent with each other and to ensure that the plan of care sets out clear directions to staff and others who provide catheter care to resident #035, to be implemented voluntarily.

WN #2: 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 failed to ensure that staff applied the physical device for restraining a resident in accordance with manufacturer's instructions.

On March 15, 2016, Inspector #573 observed resident #003 sitting in a wheelchair with a lap belt that was not positioned across the hips and had approximately more than five inches gap between the lap belt and the resident's hips.

On March 15, 2016, at approximately 0915 hours, Inspector #573 observed resident #045 sitting in a wheelchair with a front closing lap belt that was loosely applied. Again at 1047 hours inspector observed resident #045's lap belt that was not positioned across the hips and had more than approximately 10 inches gap between the belt and resident's hips. The Inspector was able to pull the lap belt up to the resident's chest.

Inspector #573 spoke with PSW #105, PSW #104 and RN #103 regarding resident #003 and resident #045's front closing wheelchair lap belt. The staff members indicated to the inspector that the wheelchair lap belt was used for resident's safety to prevent falls.

RN #103 examined resident #045 and resident #003's wheelchair lap belts and indicated that they were too loose and readjusted the front closing lap belts to fit the residents properly.

Residents #003 and #045 health care records were reviewed by inspector #573. In both resident's health records, the use for wheelchair lap belt was identified as physical restraints for fall prevention.

On March 15, 2016, the home's physiotherapist who was an Assistive Devices Program (ADP) authorizer indicated to inspector #573 that the wheelchair lap belt had to be applied properly to the resident, not too tight or loose. The expectation regarding the application of the wheelchair lap belt was that it should be two fingers gap between the belt and the resident's hips. [s. 110. (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 staff apply physical devices for restraining a resident in accordance with manufacturer's instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored were restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

The home's Documentation Room on the 2nd floor was locked by use of a keypad, the code for which was identical to other doors such as the public washroom. In the Documentation Room, a large number of various creams prescribed to many different residents were stored in an unlocked cupboard in three plastic baskets, on open shelves, and in the unlocked treatment cart.

In a locked fridge with a key in a magnetic key case on the door of the fridge was observed in the Documentation Room. In this fridge the following medication were observed:
-eight vials of Fluviral Injectable (2015-2016) 0.5ml
-seven vials of Fluad ® MD injectable

During interviews with Housekeeping staff members #120 and #125, they indicated that they knew the access code to the Documentation Room and entered the room to empty the garbage and to wash the floor as required, with or without registered staff presence. Restorative Care staff #121 indicated to the Inspector that she knew the access code to the Documentation Room and accessed it with or without registered staff presence to access resident's health records stored in the room.

The DOC indicated to Inspector #545 that she was aware that the Documentation Room was accessible to all staff, and that all areas where drugs were stored should be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

Resident bedroom #227, which occupied residents #038 and #044, was observed on March 16 and 17, 2015. On both observations it was determined that there were insufficient privacy curtains to provide privacy to either resident #038 or #044.

Bedroom #227 was equipped with a ceiling lift, the movable ceiling track of which ran lengthwise with the room near the wall with two addition stationary tracks on either side, running the width of the room near the wall. There were two privacy curtains that ran between the two resident beds, down the center of the room; the two curtains were divided by the ceiling lift track which ran lengthwise. The ceiling lift was observed to be stored nearest to the wall, when this occurred the two privacy curtains were not able to meet creating a large gap and insufficient privacy. The POA for resident #038 brought forward concerns related to this gap as resident #038 had expressed a desire for privacy. The POA also noted that due to this gap, there were times whereby he/she had been able to view care provided for resident #044, exampled by when resident #044 was placed on the commode using the lift.

In addition, due to the stationary track that ran nearest to the wall of the bedroom door, there was a gap that existed between the track and the wall, as there was no curtain currently hanging in this position. This rendered the care area for resident #044 in view, as there were insufficient curtains to provide privacy.

Inspector #148, in the company of the home's Support Services Manager, observed room #227. He noted that he was aware of resident #038's, desire for privacy but was not made aware of the deficiency in privacy curtains in this room. The Manager, agreed that there was a need to have an additional curtain between the beds to ensure that sufficient privacy was afforded no matter the position of the ceiling lift. As it related to the

missing curtain nearest to the bedroom door, the Manager indicated that this had been an ongoing challenge as the sprinkler head near the curtain track would "catch" on the curtain and tear. He suspected this was the reason it was missing at this time, but agreed it was required in order to ensure sufficient privacy for resident #044.

Resident bedroom #122, which occupied residents #009 and #048, was observed on March 15 and 17, 2016. On both observations it was determined that there were insufficient privacy curtains to provide privacy to either resident #009 or #048.

Bedroom #122 was equipped with a ceiling lift, a movable ceiling track ran the width of resident #048's bed, near the wall closest to the entry door, while an addition stationary track ran the length of the room near the head of bed. Privacy curtains existed between the wall nearest the entry door and the movable track, however, there was no privacy curtain on the opposite side of the movable track. When the lift was positioned at any point in the care area (from the wall to the center of the bed, sufficient privacy curtains did not exist to ensure resident #048 was provided with privacy. In addition, privacy curtains existed to separate bed 1 and bed 2 and were hanging from a swing track. The length of the swing track did not meet the privacy curtain that surrounded the care area for resident #009, leaving a gap whereby privacy could not be provided.

On March 17, 2016, the home's Support Services Manager was made aware of the privacy curtain deficiency in resident bedroom #122. [s. 13.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents, clearly set out what constitutes abuse and neglect.

The home has two policies representing the policy to promote zero tolerance of abuse and neglect of resident. One policy was titled Resident Abuse – Staff to Resident and the second was titled Resident Abuse by Persons Other than Staff, both policies, with #OPER-02-02-04 and dated September 2015.

Upon review of both policies it was determined that the definitions of emotional, physical and verbal abuse and neglect were not consistent with the definitions of O.Regulation 79/10, s.2(1) and s.5. The definition of emotional abuse did not include: insulting, humiliating, shunning, ignoring, infantilization or lack of acknowledgement by anyone or emotional abuse by a resident that understands and appreciates its consequences. The definition of verbal abuse did not include: verbal communication of a belittling nature which diminishes a resident's sense of well-being dignity or self-worth made by anyone other than a resident or made by a resident that understands and appreciates its consequences. The definition of physical abuse did not include the administration of a medication for an inappropriate purpose or physical abuse by a resident to another resident. The definition of neglect indicates "immediate jeopardy", whereas the LTCHA, 2007, did not indicate jeopardy need be immediate to be neglect. The definition of neglect within the home's policy was further limited by indicating that neglect was a failure to provide treatment, care, services, assistance which is reasonably expected in the relationship.

The home's policy to promote zero tolerance of abuse and neglect of residents, does not set out what constitutes abuse as indicated by the LTCHA, 2007. [s. 20. (2)] (148) [s. 20. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

Resident #039 indicated to the inspector during an interview that staff got him/her up very early in the morning and that he/she would prefer to get up later, closer to breakfast time.

Breakfast was served daily at 0830 hours on this specific unit.

On March 17, 2016 at 0740, the inspector observed the resident, eyes closed in a reclined wheelchair in the hallway by the resident's bedroom.

Upon review of resident #039's health record, it was indicated that the resident required extensive assistance of 2-staff for bed mobility and for all transfers via mechanical lift. There was no information related to the resident's sleep patterns and preferences.

During an interview with PSW #115, she indicated that she was the resident's primary caregiver. She indicated that she did not know if the resident had any preference related to wake time, added that she got the resident up whenever a second staff was available to assist with the transfer as a mechanical lift was required, and that was usually around 0730.

RN #100 indicated that upon return from hospital in December 2015, resident #039's was receiving a specific type of care. She indicated that the resident improved over the last few months, and now agrees to get up for breakfast. The RN indicated that the resident's sleep patterns and preferences was usually assessed upon admission, was included in the 24-hour care plan then added to the current plan of care, however for this resident, information regarding sleep patterns & preferences was not found. [s. 26. (3) 21.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #032 has multiple diagnoses contributing to pain and weakness. According to the most recent assessment conducted in January 2016 which indicated, in the last seven calendar day's physiotherapy treatments were administered three days for 15 minutes each.

Inspector #573 reviewed resident #032's written plan of care in effect and recent physiotherapy quarterly assessment. The resident's plan of care and quarterly physiotherapy assessment identified that the resident was in physiotherapy treatment for multiple interventions including passive stretching, strengthening exercises, hot pack to specific limb areas and therapeutic ultra sound treatment to two specific areas. The frequency of the physiotherapy interventions indicated two to three times a week.

Upon reviewing resident #032's physiotherapy daily attendance sheets for the month of January 2016 and February 2016, it was indicated that:
-for the week of January 04-08, 2016: No physiotherapy treatments;
-for the week of January 11-15, 2016: Strengthening exercises and hot pack provided on one specific date;
-for the week of January 18-22, 2016: Strengthening exercises on one specific date;
-for the week of January 25-29, 2016: Strengthening exercises on three specific dates;
-for the week of February 01-05, 2016: Strengthening exercises and passive stretching provided on one specific date;
-for the week of February 08-12, 2016: Strengthening exercises on one specific date
-for the week of February 15-19, 2016: Strengthening exercises on one specific date; and

-for the week of February 22-26, 2016: Strengthening exercises on one specific date.

On March 21, 2016, physiotherapist assistant (PTA) indicated that resident #032 was not provided with all the physiotherapy interventions in place and also was not seen two to three times per week as per the plan, since the resident refused the specific interventions and also physiotherapy treatments.

Inspector #573 reviewed the physiotherapy daily attendance sheets and the resident's progress notes for the month of January 2016 and February 2016. No information was found to indicate that resident #032 refused any specific physiotherapy interventions and there was no documentation regarding resident refusals of physiotherapy treatments on specific days when treatment was not provided.

On March 21, 2016, the home's physiotherapist indicated to Inspector #573 that resident #032 required all the physiotherapy interventions as per the plan of care. After reviewing the physiotherapy daily attendance sheet the physiotherapist agreed with the Inspector that resident #032's response to the physiotherapy interventions and treatments were not documented. [s. 30. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device if the restraining of the resident was included in the resident's plan of care.

On March 14 and 18, 2016, resident #026 was observed seated in a wheelchair with a front closing lap belt. On March 18, 2016, on two separate occasions, when Inspector #573 requested resident #026 to undo the front closing wheelchair lap belt, resident #026 could not undo the lap belt.

Upon review of the resident's health record, it was indicated that no restraints were in use for resident #026 at the last assessment on a specified date in February 2016. The written plan of care was reviewed by the Inspector and there was no indication that resident #026 required a wheelchair lap belt as a restraint.

On March 18, 2016, during an interview, PSW #118 stated that she applied the wheelchair lap belt for resident #026's safety to prevent from falls. Further PSW #118 indicated that she was not aware that resident #026 was physically incapable of removing the wheelchair lap belt.

In an interview on March 18, 2016, RN #100 indicated to Inspector #573 that the resident did not have any restraints and PSW staff members were not to apply a wheelchair lap belt restraint to resident #026. [s. 31. (1)]

WN #9: 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 has failed to ensure that resident #026 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 #026 was diagnosed with several medical conditions, including dementia, depression, and osteoarthrosis. According to the most recent assessment, the resident had some natural teeth loss, broken, loose or carious teeth and required extensive assistance of two staff for personal hygiene, including brushing of teeth. There was no indication of resistance to care.

During a family interview, it was indicated to Inspector #545 that staff were not providing oral care as the resident was often refusing.

On March 18, 2016 at 1000 hours, Inspector #545 observed resident #026 with unclean teeth and denture missing in the resident's mouth. The denture was observed in a denture cup in a small amount of clear water. When asked if the denture was his/hers, the resident indicated "No", but then took the denture from the opened denture cup and put it in his/her mouth.

During an interview, PSW #118 indicated that she had not provided oral care to resident #026 on March 18, 2016. She added that the resident often refused when she tried in the past to provide oral care.

PSW #122 indicated that on evening shift, the resident often refused to open his/her mouth and that is was difficult to provide oral care. She further indicated that cleaning tablets were not provided to this resident as the resident did not let staff remove the denture at night for cleaning. She indicated that when she brushed the resident's teeth recently, she noticed bleeding gums. The PSW indicated that she did not document refusal of oral care or report it to the registered staff.

During an interview with RPN #123 she indicated that she was not aware that the resident was refusing oral & denture care, as it had not been reported to the registered staff. [s. 34. (1) (a)]

WN #10: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009 and resident #020 were served course by course meals.

On March 14, 2016, during lunch service in a specific dining room, Inspector #573 observed resident #009 and #020 being served with a dessert cup while still having their main course meal. At a specific table the inspector observed 50% of the main course meal still remaining on resident #020's plate. Resident #009's and #020's care plan were reviewed, and there was no indication that meals should not to be served course by course. [s. 73. (1) 8.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On March 17, 2016, during lunch service in the same dining room, at 1158 hours, resident #046 and resident #047, at a specific table, were served soup. Inspector #573 observed both the residents did not attempt to feed by themselves. Seven minutes after receiving the soup, at 1205 hours an Activity staff member came to the dining room, sat next to the residents and assisted with the feeding.

At 1158 hours, at another table, resident #003 was served soup. At 1205 hours, Inspector #573 observed resident #003 did not attempt to feed by self. Twelve minutes after receiving the soup, at 1210 hours an Activity staff member came to the dining room, sat next to the resident and assisted with the feeding.

At 1205 hours, at different table, resident #005 was served with the main course meal. At 1212 hours PSW #112, after assisting two other residents at the same table sat next to resident #005 and assisted with the feeding.

Inspector spoke with the PSW #112 who indicated that resident #005 required almost total assistance for feeding.

Health care records for ADL eating was reviewed by Inspector #573 which indicated, resident #046 and #047 were total dependent with one staff for feeding. For resident #003 and #005, the health care record indicated that extensive assistance of one staff was required for feeding. [s. 73. (2) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act that procedures were implemented for addressing incidents of lingering offensive odours.

The home's current procedures for addressing incidents of lingering offensive odours, titled: Dealing with Persistent Odours, HL-05-03-08, last revised September 2015 was reviewed by Inspector #545. On page 1 of 1, it was documented that "the home will investigate and correct all complaints and reports of unacceptable lingering odour as soon as possible".

On March 15, 16, 17 and 18, 2016 Inspector #545 observed a lingering offensive odor near the end of a specified hallway on a specified unit, near a specified room.

RPN #101, Housekeeping staff member #120, the Support Services Manager, the Director of Care and the Administrator confirmed that there was a lingering offensive odor around, and in a specified room, and that it had been an issue for a long time.

Housekeeping staff member #120 indicated that on March 16, 2016 he had observed an offensive odour in the specified room. He indicated that he wiped the resident's bedroom and bathroom floors using a neutralizer product to clean coffee spills as well as urine spills. He indicated that the home's urine eliminator product called Aromx 62 Deodorizer had not been used week of March 15, 2016 when he wiped the floor in the specified room. The housekeeping staff further indicated that on March 18, 2016 he noticed that the Vaportek Ecoz Odor Neutralizer machine installed in the specified room for odor management, had been unplugged. [s. 87. (2) (d)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

In accordance with subsection 23 (1) of the Act, the licensee of a long term care home shall ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated.

At the supper meal service on a specified date in November 2015, PSW #112 was providing feeding assistance to resident #022. PSW #112 was overheard by a visitor to use explicit language and was telling the resident to "hurry up, let's get this done" in a manner and tone that was concerning to the visitor. The visitor believed he/she had reasonable grounds to suspect this as abuse and reported it immediately to the charge nurse. The home took immediate action, including an investigation whereby the home concluded the staff member's conduct to be inappropriate. The investigation conducted by the home's Administrator and DOC, concluded with a disciplinary letter on specified date in November 2016 and final report to the Director on a specified date in December 2016.

On March 17, 2016, Inspector #148 spoke with the home's Administrator, DOC and with the POA for resident #022, whereby it was determined that the POA was not notified of the results of the investigation. [s. 97. (2)]

Issued on this 6th day of April, 2016

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

Original report signed by the inspector.