Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 13, 2015	2015_200148_0008	O-001544-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE STARWOOD
114 STARWOOD ROAD NEPEAN ON K2G 3N5

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

AMANDA NIXON (148), MELANIE SARRAZIN (592), RENA BOWEN (549)

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): February 2-6 and February 9-11, 2015.

Three complaint inspections and two critical incident inspections were also completed during the time of this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Director of Activities, Support Services Manager, Registered Nurses (RN) and Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Aids, family and residents.
In addition the Inspector(s) reviewed resident health care records, family and resident council meeting minutes, the home's complaint policy and observed medication administration, resident care and staff/resident interaction.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Training and Orientation

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

11 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. 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 the restraining of Resident #20 by a physical device was included in the resident's plan of care.

Resident #20 was observed the morning of February 2, 2015 in wheel chair with a tilt applied. On the same date, during the lunch meal service, the resident was observed in the same wheel chair, at a 90 degree angle with a table top applied. Staff feeding the resident indicated that the table top was to assist the resident during meals, whereby the resident is placed at a 90 degree angle to provide for a safe feeding position, and the table top prevents the resident from sliding out of the chair. On February 4, 2015, the resident was observed at 9:30am and again at 9:45am, to be seated in the wheel chair at a 90 degree angle with the table top applied, the resident was resting in the hallway with no food or fluid. On the same date, the resident was observed at 11:30am to be seated in the wheel chair with tilt and table top applied. The table top remained applied, up to and including the lunch meal service.

The resident’s health care record including, plan of care and physician orders, indicates the use of a table top as a personal assistance services device to be applied at meals and nourishments. It was determined through observation, staff interviews and the resident's health care record that the resident requires total assistance for eating and is not able to participate in this activity of daily living.

Staff interviews indicate that the use of the tilt on the wheel chair, for Resident #20, is to prevent the resident from sliding out of the chair. The table top, in part, is applied when the chair is placed at a 90 degree angle for meals and nourishments, to prevent the resident from sliding out of the chair and therefore to prevent injury.

The observations above and the intent of the physical device indicate that the table top is not used as a PASD under s.33 of the Act but rather as a restraint under s.31 of the Act. As such, Resident #20 is restrained by a physical device without having the restraining of the resident included in the resident’s plan of care and satisfying the requirements of s.31 (2). [s. 31. (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 a resident restrained by a physical device only if it is included in the resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe positioning devices or techniques when assisting Resident #49.

On a specified date, Resident #49 was send to the hospital following a fall, resulting in injury. The incident occurred during bathing care as the PSW was drying the resident, while seated on the elevated bath lift chair without the seat belt applied. The PSW, providing the bathing care, turned her back to reach needed supplies and during this time the resident slipped out of the chair and sustained an injury.

Upon review of the health care record for Resident #49, the resident is diagnosed with severe dementia and requires assistance of one staff to stand and walks with a walker. Resident #49 was identified as being at moderate fall risk with one staff extensive assist when staff are providing bathing care to resident.

During an interview with PSW #S117 and PSW #S118, both reported to Inspector #592 that the bath lift chair is equipment used for the transfer and positioning of the resident when bathing. The PSWs further reported that the home's policy is to have the seat belt on at all times when using the bath lift chair. PSW #S117 demonstrated that two memos are posted beside the tub, both indicate: "THERE MUST BE A SAFETY BELT USED FOR ANY RESIDENT HAVING BATH OR SHOWER".

The Inspector spoke with the ADOC related to the incident described above and the strategies in place to reduce and mitigate falls. The ADOC indicated that when a resident is seated in the bath lift chair and the chair is elevated, whereby the resident's feet are no longer touching the ground, that the seat belt of the chair should be secure around the resident's waist. It was described by the ADOC that the results of the home's investigation was that the bath lift chair was slightly elevated and that seat belt was not applied at the time of the incident.

As such, staff did not use safe positioning devices or techniques while using the bath lift chair for Resident #49 resulting in a fall and injury.
[Log O-001254-14] [s. 36.]

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 use safe positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff have received annual training related to the safe and correct use of mechanical lifts.

In accordance with O. Reg. 79/10, s. 218 (2) and s.219 (1), staff shall be provided with training prior to performing their responsibilities and annually thereafter, in the safe and correct use of equipment, including therapeutic equipment, mechanical lifts, assistive aids and positioning aids, that is relevant to the staff member's responsibilities.

On a specified date, Resident #49 was send to the hospital following a fall, resulting in an injury. The incident occurred during bathing care as the PSW was drying the resident, while seated on the elevated bath lift chair without the seat belt applied. The PSW, providing the bathing care, turned her back to reach needed supplies and during this time the resident slipped out of the chair and sustained an injury.

During an interview on February 11, 2015, the ADOC stated that the results of the investigation concluded that the mechanical bath lift chair was elevated and that the seat belt was not applied at the time of the incident. The ADOC confirmed that the direct care staff receive training in the safe and correct use all mechanical lifts including the mechanical bath lift chair during orientation. However, the ADOC stated that the direct care staff have not received annual training thereafter in the safe and correct use of any of the home's mechanical lifts including the mechanical bath lift chair.
[Log O-001254-14] [s. 76. (4)]

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 receive annual training related to the safe and correct use of equipment, relevant to their responsibilities, including mechanical bath lift chairs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that Resident #20 was afforded privacy in treatment and in caring for his/her personal needs.

Inspector #148 observed the tub/shower room door to be open on the 2 North unit. The inspector could view into the tub/shower room and noted two areas of the privacy curtain that were open approximately four inches. The inspector could view one staff filling the tub and Resident #20. The resident was sitting in the bath chair, facing the doorway without any clothes on. The inspector indicated to the staff member in the room that the door needed to be closed as the privacy curtain was not affording the resident privacy during the care. [s. 3. (1) 8.]

2. The licensee has failed to ensure that Resident #46 was afforded the right to give or

refuse consent to any treatment, care or services for which consent is required by law and to be informed of the consequences of giving or refusing consent.

During an interview with Inspector #592, Resident #46 indicated that the home violated his/her rights by giving a treatment which he/she clearly communicated refusal. Resident #46 is able to make daily care decisions and is able to verbalize personal preferences related to medication administration.

On an identified date, Resident #46 was offered an antiviral by RPN #S116. The resident told the nurse that he/she had already expressed a refusal for this medication to another nurse and to the physician. The resident reported that he/she was offered the antiviral again on a separate date by RPN #S116 and again expressed his/her refusal for the medication.

The resident reported that on a day after the second offer of the antiviral, the resident noticed a "funny" taste in his/her crushed medication which were mixed in chocolate pudding. The resident inquired with the RPN administering the medication if any medications had been changed or added. The resident was told by the RPN that the antiviral medication was added to the crushed medications. Resident #46 indicated to the RPN that they did not have the right to conceal the antiviral in the crushed medications and that he/she had previously made it clear that he/she did not want to take the antiviral medication. The RPN indicated she had not been informed of the resident's refusal and that three doses had been administered.

The Medication Administration record was reviewed for the period of time reported by the resident. The records indicate that antiviral medication was prescribed and it was recorded that Resident #46 was administered the antiviral medication on three separate occasions. The Medication Administration record also indicates that the resident refused the antiviral on two separate occasions.

During an interview with RPN #S116, who is familiar with the resident's care, it was reported that it is apart of her practice to inform the Resident #46 of the medications she will administer prior to crushing the medications, specifically when there is change to his/her daily medications. RPN #S116 confirmed the two occasions that the resident refused the antiviral medication. It was confirmed by the RPN and the health care record that both refusals were documented in the progress notes.

During an interview with the DOC, it was reported that the home was made aware of the

incident by the resident on January 9, 2015. The DOC acknowledged to Inspector #592, that the administration of the antiviral medication did not respect the resident's rights and that interventions were put in place to ensure that nursing staff will not administrate the antiviral to this resident again. [s. 3. (1) 11. ii.]

WN #5: 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. (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 there is a written plan of care for each resident that sets out the planned care for the resident.

Resident #40 has a chronic skin condition. RN #S101 stated that there are affected areas of the skin on both of the resident's arms, trunk and scalp. Inspector #549 observed several the affected areas of the resident's arms during the inspection. Resident #40 has a prn prescription of a topical corticosteroid to be applied to the affected areas, twice daily as required.

On February 5, 2015 PSW #S105 stated to Inspector #549, that she is aware that Resident #40 has the chronic skin condition on the arms, trunk and scalp. PSW #S105 stated that she provides assistance to PSW #S104 with the resident's bath and stated that they are aware that a topical corticosteroid cream is available should the resident's skin condition be symptomatic.

PSW #S104 who is the resident's primary care giver on the day shift stated that she is aware of the topical corticosteroid cream for Resident #40 related to the chronic skin condition.

Inspector #549 reviewed the plan of care for Resident #40 related to the chronic skin condition, which is not in the written plan of care. RN #S101 confirmed with Inspector #549 that the written plan of care did not include the planned care for Resident #40 related to the topical corticosteroid cream for the resident's skin condition.

Resident #39 has a diagnosis of Type 2 diabetes mellitus. PSW #S106 who is the resident's primary care provider on the day shift stated to Inspector #549 that she is aware that the PSW is not to cut the resident's toe nails due to being "diabetic".

PSW #S106 stated to Inspector #549 that the "Registered Nurse or the Foot Care Nurse will cut the residents toe nails, we have to ask them". PSW #S106 also stated that the PSWs are to "notify the registered staff if there are changes in the condition of the resident's feet or skin due to his diabetes".

Inspector #549 reviewed the written plan of care for Resident #39 related to foot care and skin integrity and the direction related to foot/skin care, is not in the written plan of care.

RN #S101 confirmed with Inspector #549 that the written plan of care did not include the planned care for Resident #39 related to the resident's foot care and skin integrity. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident #20 was observed the morning of February 2, 2015, in wheel chair with tilt applied. On the same date, during the lunch meal service, the resident was observed with a table top applied to the wheel chair. Staff feeding the resident indicated that the table top was to assist the resident during meals, whereby the resident is placed at a 90 degree angle and the table top prevents the resident form sliding out of the chair. On February 4, 2015, the resident was observed at 9:30am and again at 9:45am, to be seated in the wheel chair at a 90 degree angle with the table top applied, the resident was resting in the hallway with no food or fluid. On the same date, the resident was observed at 11:30am to be seated in the wheel chair with tilt and table top applied. The table top remained applied, up to and including the lunch meal service.

Direction is provided on the device, which indicated "tilt the wheelchair at all times" and "table top for meals and nourishments times only". The physician orders indicate, "may use table top while in wheelchair for meals and nourishment times" and "may use regular wheelchair with tilt while up to ensure promote proper positioning".

The plan of care indicates that the resident may use a table top in wheel chair for meals and nourishment times and is totally dependent for assistance with eating, must be seated upright at 90 degrees for meals and when resident is in the wheelchair it is tilted at all times to prevent sliding out of the chair.

Inspector #148 spoke with RN #S100, who indicated that the tilt is applied at all times, if no one is around. In relation to the table top the RN indicated it is used at meal and nourishments times, for activities and used by family when visiting. Inspector #148 spoke with three PSWs who are familiar with the resident's care, who indicated that the table top is used by the resident to rest her arms and not used to assist with meals as the resident requires total feeding assistance. The PSWs further indicated that the tilt is used for positioning, and that the resident is usually in the tilt.

The use and application of the tilt and table top are not clear to staff who provide direct care as exampled by the above observations and interviews of staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care was provided to Resident #21 as set out in the plan of care.

The plan of care for Resident #21, indicates the resident is at risk for falls. As part of the interventions to prevent falls, the resident is to have a chair alarm attached when seated in wheelchair.

On February 2, 2015, Resident #21 was observed in his/her wheelchair at the end of the unit hallway with the chair alarm applied. On Tuesday, February 3, 2015 at 9:25am the resident was seated in the wheelchair dressed in housecoat, near the nursing station without the chair alarm applied. Staff were observed to move the resident down the hallway where the resident was placed outside room 224, the resident remained without the chair alarm until after the resident received his/her bath.

On Tuesday February 10, 2015, the resident was observed to be seated in his/her wheelchair dressed in a housecoat. The resident was seated in a common space and did

not have a chair alarm in place. A review of the unit's bathing schedule indicates that the resident is scheduled for a bath on Tuesdays.

Observations demonstrate that the resident was not provided with a chair alarm, as per the plan of care, on two separate occasions, which correspond to the resident's schedule bath day. [s. 6. (7)]

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 has failed to ensure that the equipment, specifically the resident-staff communication and response system, has been maintained in a good state of repair.

On February 3, 2015, while testing the function of the call bell in an identified resident bedroom, Inspector #592 discovered that the communications system did not activate when the button at the end of call bell cord was pressed. There was no audible sound and the system dome light outside of the bedroom did not illuminate.

During an interview with Resident #10, who resides in the bedroom, it was reported that the resident did press the button on the call bell cord several times in the past few days, whereby the system did not activate. The resident reported that staff told him/her that he/she was not pressing hard enough on the button.

The Inspector reported the disrepair of the resident-staff communication and response system to the Support Services Manager, in the presence of the Administrator, the Support Services Manager indicated that this issue would be repaired.

Later, on the same day, it was verified by Inspector #592, that the communication system was in working order, whereby pressing the call bell button initiated an audible sound and an illumination of the dome light outside of the bedroom. The communication system was observed to be in working order. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

During an interview on February 3, 2015, with Resident #10, Inspector #592 observed the the resident-staff communication system was not easily accessible to the resident or the Inspector.

Inspector #592 located the call bell cord to be pinned between the wall and the resident's side rail, hanging on the floor. Inspector #592 had to push the bed away from the wall and use force to pull on the cord in order to have the call bell accessible for the resident.

It was demonstrated that the resident staff communication system was not easily accessible to the resident or visitor at the time of this observation. [s. 17. (1) (a)]

WN #8: 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:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care must be based on, at a minimum, an interdisciplinary assessment of dental and oral status including oral hygiene.

The plan of care for Resident #21, for personal hygiene includes that the resident requires 2 person assist and encouragement for oral care.

The most recent Minimum Data Set (MDS) Assessment and related Resident Assessment Protocol (RAP) indicate the resident is missing some or all of his/her natural teeth. Inspector #148 spoke to staff familiar with the resident's care, who reported that the resident does not have any of his/her natural teeth, has refused to wear dentures and is provided swabs for oral care in the morning and evening. The Inspector noted that both toothbrush and toothpaste were available in the resident's personal items basket, staff confirmed the resident does not use either of these items.

The written plan of care does not provide for the current dental and oral status, including the oral hygiene that is to be provided to the resident. [s. 26. (3) 12.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response is made in writing within 10 days of receiving Residents' Council's advice related to concerns or recommendations.

On February 6, 2015, the Residents' Council Minutes for September 4, 2014 up to December 4, 2014 were reviewed.

Several concerns were identified and brought forward by the Residents' Council on September 4, 2014 including:
- Showering/bathing-resident being rushed and that staff barely put soap to skin
- Staff speaking French to residents who do not speak French
- PSW not making beds correctly
- Air conditioning being too cold
- Missing clothing in laundry
- Access to the gazebo in garden difficult for wheelchairs
- Flies and fruit flies everywhere

No written responses were found to address these concerns.

Concerns were identified and brought forward by the Residents' Council on December 4,2014:

- Hangers taken out of a resident bottom drawers
- Cream soup is too thick, black stuff on the coffee and tea mugs

No written responses were found to address these concerns.

During an interview with the Administrator on February 6, 2015, it was reported that she was not aware of the process used by the home's managers to respond to Resident Council concerns or recommendations. On February 9, 2015, the home's Administrator, reported that she was not able to provide written response to the concerns/recommendations noted above. The Administrator reported that at this time, the Managers did not respond in writing to any of the concerns/recommendations brought forward by the Residents' Council. [s. 57. (2)]

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. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

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 did not ensure that residents who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required.

Inspector #148 observed a table of four residents: Resident #41, #42, #43 and #44, in relation to the provision of feeding assistance.

On February 2 and 6, 2015, Resident #42 was observed at the lunch meal service. On February 2, 2015, the resident was provided the main meal at 12:20pm. The resident was not observed to feed him/herself and physical feeding assistance was not provided until 12:50pm. A staff member, who was providing physical assist to two other residents at a different table, was providing intermittent encouragement and physical assist to tablemates and indicated no staff were available to provide physical assist until the coffee and tea cart was distributed. On February 6, 2015, the resident was provided the main meal at 12:20pm. The resident was not observed to feed him/herself and no staff approached the resident to assist with feeding until 12:40pm. The plan of care for Resident #42 indicated that feeding assistance may vary from cueing to extensive assistance. Staff providing assistance indicated that the resident regularly needs physical feeding assistance.

On February 2, 2015, Resident #43 and #44 were provided the meal at approximately 12:20pm. The plan of care for resident #43 indicates the need for varied feeding assistance up to extensive assistance. The plan of care for resident #44 indicates the need for total feeding assistance. Both residents were provided the meal at approximately 12:20pm, neither resident made an attempt to feed self during the observation period. Resident #43 and #44 were provided physical feeding assistance by a staff member at 12:40pm.

Observations of the lunch meal service on February 2 and 6, 2015, demonstrate that three identified residents, who require assistance with eating, were provided a meal prior to someone being available to provide that assistance. [s. 73. (2) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written notice is provided to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

In accordance with O.Regulation 79/10, s.148(1), every resident that is discharged from the home, with the exception of a discharge due to a resident's death, is provided notice of the discharge as far in advance of the discharge as possible or if circumstances do not permit notice to be given before the discharge, as soon as possible after the discharge.

On a specified date, Resident #45 was admitted to the long term care home from hospital. During the resident's stay at the home the resident was resistive to care, would refuse medications and have both verbal and physical outbursts. On a specified date, an incident occurred which precipitated the resident being sent to hospital. Days later, the home held discussions with the resident's Power of Attorney for Care (POA) and the medical teams at the home and hospital. It was decided that due to the instability of the resident's mental health the resident was at risk to self and others at the long term care home and the resident was discharged.

Inspector #148 spoke to the DOC about the circumstances surrounding the discharge of Resident #45 and it was confirmed that although the resident's POA was involved in the discharge planning, written notice was not provided to either the resident or the resident's substitute decision maker. [Log O-00676-14] [s. 148. (2)]

Issued on this 18th day of February, 2015

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

Original report signed by the inspector.