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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2014	2014_191107_0025	H-001470-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF NIAGARA
2201 ST. DAVID'S ROAD, THOROLD, ON, L2V-4T7

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

GILMORE LODGE
50 Gilmore Road, Fort Erie, ON, L2A-2M1

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

MICHELLE WARRENER (107), BARBARA NAYKALYK-HUNT (146), ROBIN MACKIE (511)

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): November 5, 6, 7, 12, 13, 14, 2014

CIS H-000373-14 was completed during this inspection and findings were included in this RQI report

During the course of the inspection, the inspector(s) spoke with Residents, family members, Representatives from Residents' Council and Family Council, the Administrator, Director of Care (DOC), Dietary, Laundry & Housekeeping Manager, Resident & Community Programs Manager, CDI Coordinator, Administrator's Assistant, Registered Nursing staff, front line nursing and dietary staff

During the course of the inspection, the inspector(s) Toured the home, reviewed clinical health records, relevant policies and procedures, observed the provision of care, observed dining service

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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.
On November 7, 2014, inspectors observed five out of five windows in resident bedrooms that could be cranked open to 30 centimetres (cm). There was a chain attached to each window and the window frame and the chain was broken mid-point. The home reported that the chains had been installed to limit the ability to open the window to 15 cm. The chains had broken as a result of forcible useage. The windows were repaired by end of day November 7, 2014 to limit the opening to 15 cm. [s. 16.]

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 with ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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

Findings/Faits saillants :

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

A) The plan of care for resident #033 identified the resident preferred a shower; however, the resident was consistently recorded as receiving a tub bath. During interview, one Personal Support Worker (PSW) stated the resident was unable to have a shower and stated the shower area would trigger behaviours. A different PSW stated they always provided a shower for the resident and that the large tub caused responsive behaviours in the resident. Documentation did not include any incidents of responsive behaviours related to bathing; however, the PSW stated it was reported to registered staff. Registered staff were also unclear if the resident required a shower or a bath. The resident was unable to voice their preference to the inspector. The plan of care was inconsistent with the method of bathing being provided and different staff were not consistent in their approach to the resident's bathing requirements.

B) The plan of care for resident #039 instructed staff to complete oral care by removing and brushing partial plate and remaining teeth and re-insert the plate every morning and evening. Documentation of "Dentures Applied" under the "Tasks" section of Point Click Care noted only two instances where the resident's dentures were recorded as being applied or removed over a 13 day period. Staff recorded "Not Applicable" and "Does not wear dentures" on many of the records. Staff interviewed stated the resident wore dentures consistently with the occasional refusal to remove the dentures. Three instances of resident refusal were noted. Documentation was not consistent between the resident wearing the dentures and the documentation reflecting "Not applicable" or "Does not wear dentures". [s. 6. (4) (b)]

2. 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.

The plan of care for resident #046 directed staff to provide care with two staff members due to resident's responsive behaviours and also, if resident resisted care to leave and reapproach in 5 to 10 minutes. On a specified date, a Registered Practical Nurse (RPN) attempted to provide care and change an incontinent product on resident #046 alone. The resident was resisting care. The nurse did not follow the plan of care. This was confirmed by the Administrator and the home's investigation notes. [s. 6. (7)]

3. The licensee failed to ensure that residents were reassessed and their plans of care revised when their care needs changed.

Resident #029 was not reassessed when their care needs changed in relation to swallowing. The resident's diet was changed related to swallowing. Documentation in the progress notes did not identify continuing concerns with the resident's swallowing ability after the diet change until two months later when the resident was documented as having difficulties swallowing. Documentation in the physician's orders identified the resident may be aspirating. During interview, the physician stated the resident was aspirating every time the resident swallowed. The Nutrition Manager confirmed that a referral to the Registered Dietitian was not completed when the resident's condition changed in relation to swallowing and the resident's diet texture and consistency of fluids were not re-assessed when the swallowing concerns were identified. [s. 6. (10) (b)]

WN #3: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy for Abuse and Zero Tolerance RR00-001 was complied with.

The home's policy directed that any report of an alleged or witnessed incident of abuse or neglect must be reported to the DOC, Administrator or designate immediately. On a specified date, a PSW suspected that abuse may have occurred but did not report the allegation until two days later. The PSW and Administrator confirmed that the policy was not complied with. [s. 20. (1)]

WN #4: 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:
1. Customary routines. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of 1. resident's customary routines.

During an interview with resident #002, they stated their bath days were too close together. The resident stated their routine was not to have their baths that close together. The resident stated that they talked about their concern to the staff and staff said they could not change the bath day because there was a bathing schedule. Interview with the RPN confirmed the resident was on a bathing schedule for days that were two days apart and that on admission the resident would have indicated the bath days they would prefer. A review of the resident's admission form, identified the bathing was originally scheduled for different days of the week. The clinical records did not indicate when the bathing day had changed or that the resident was consulted on the change. A review of the Point of Care bathing record, over a five week period, confirmed the resident refused five of their bath days on the one particular day of the week and another bath was not given in replace of these days. [s. 26. (3) 1.]

2. The licensee failed to ensure that resident #038's plan of care was based on an assessment of the resident's type and level of assistance required for grooming in relation to their facial hair. The resident was observed with a large amount of white hair on their chin about 1/4 inches long on November 5, 12, 13, 2014. The resident's plan of care stated the resident required extensive assistance of two staff for hygiene and grooming; however, the plan did not identify the need for the resident to be shaved. Personal Support Workers interviewed stated the resident routinely had a lot of facial hair and that the resident's facial hair was to be removed during bathing or whenever it was noticed if more frequently. The resident received a bath during the observed time period; however, was observed with significant facial hair. [s. 26. (3) 7.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that sufficient time was provided for residents to eat at their own pace at the lunch meal November 5, 2014. Dessert was placed on the table while residents #032 and #045 were still consuming their entrees. The residents had not asked for the dessert prior to it being placed on their tables. Staff distributing the desserts was repeatedly heard saying, "Is [the resident] done yet?" for resident #037 and other residents who were taking longer to consume their meals. The end of the meal service was rushed for residents who took longer to consume their entrees. Interview with the Dietary, Laundry & Housekeeping Manager confirmed that this was not consistent with the home's policies for meal service and course by course service. [s. 73. (1) 7.]

Issued on this 4th day of December, 2014

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