Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2013	2013_188168_0010	H-000072-13	Resident Quality Inspection

Licensee/Titulaire de permis

HENLEY HOUSE LIMITED
200 RONSON DRIVE, SUITE 305, TORONTO, ON, M9W-5Z9

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

THE HENLEY HOUSE
20 Ernest Street, St. Catharines, ON, L2N-7T2

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

LISA VINK (168), GILLIAN TRACEY (130), TAMMY SZYMANOWSKI (165)

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 5, 6, 7, 11, 12, 13, 14, 15 and 19, 2013

This inspection report contains finding of non-compliance identified during a Complaint Inspection, log #H-01777-12, for resident #777, which was conducted concurrently with inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Medical Director, Registered Dietitian (RD), Personal Support Workers (PSW), Registered Practical Nurse (RPN), Registered Nurses (RN), Resident Assessment Instrument (RAI) Coordinator, Family Council Co-Chair, President of Resident Council, Restorative Care Aide, Recreation Supervisor, Environmental Services Manager, Physiotherapist, families and residents.

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

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Trust Accounts

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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).
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

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 of the long-term care home did not ensure that all requirements are met with the respect to the restraining of a resident by a physical device under section 31 or section 36 of the act:
1) Staff apply the device in accordance with any manufacturer's instructions.

a) On February 5 and 11, 2013, residents #443 and #700 were noted wearing devices which were loose fitting and not snug to their abdomens. The physical devices were not applied in accordance with the manufacturer's instructions. Interviews with staff on February 11, 2013, confirmed that both of the devices were restraints and could not be removed by the residents. Staff were aware, based on education that they had received, that the specific devices used to restrain a resident should be tightened to the distance of approximately 2 finger widths. The devices observed on February 5 and 11, 2013, were approximately 4-5 inches from the residents abdomen, which is not consistent with manufacturer's instructions.
b) Resident #603 was observed on February 13, 2013 at 15:25 hours with a loose device. The resident was observed pulling the device out until it reached the end of the device. A PSW tightened the device however; stated that the resident pulls the device loose.
c) Resident #472 was observed on February 13, 2013 at 14:30 hours to have a device applied loosely. The PSW confirmed that the device was applied loose. On February 14, 2013 at 10:30 hours the resident was observed to have the device applied loosely for a second time. The PSW confirmed that the device was applied with a space that was greater than two fingers between the resident's pelvic crest and the device. [s. 110. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 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:
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).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was afforded privacy in treatment and in caring for his or her personal needs.

a) On February 6, 2013, resident #504 was seated in a wheelchair in the hallway outside of the bedroom when he expressed the urge to use the bathroom. Staff responded to the resident's request but did not porter the resident to the bathroom. The resident was observed standing in the hallway with the assistance of staff holding a urinal to allow the resident to relieve himself. The resident's backside was fully exposed to those in the area of the hallway. Staff acknowledge this action was not appropriate.

2. The licensee did not ensure that every resident was protected from abuse.

a) On a specified date in 2012, staff responded to resident #459 screaming and found resident #504 standing over them holding their hands while trying to kiss them. The record indicated resident #504 had tried kissing resident #459 twice that day and that the resident did not want to be kissed, the resident had screamed, "no".
b) On a specified date in 2012, staff reported witnessing resident #504 touching the breast of resident #459. Staff intervened to separate the residents. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse and afforded privacy in caring for their personal needs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 plan of care does not set out clear directions to staff and others who provide direct care to the residents.

a) The plan of care in place at the time of the resident's death, did not provide clear direction to staff providing care. Resident #777, sustained an injury on a specified date in 2012, was admitted to the hospital and returned to the home during the same month, and passed away the following month. The plan provided conflicting directions as it identified that the resident was to remain in bed at all times and noted the injury, however it also stated that the resident shall be: portered to activities, encouraged to self propel in the wheelchair, supervised in transfers from bed to wheelchair, on a toileting routine and on a walking program.

b) Resident #777 had a known history of dressing and redressing self despite requiring assistance to complete this task during the regular care routine as per staff interviews. The plan of care, in place, at the time of the resident's fall, only identified the level of assistance required to complete dressing and the need to ensure that clothing was changed twice a day. The plan did not include the resident's known behaviour or interventions to manage the behaviour.

c) The plan of care for resident #459 identified they required extensive assistance with bed mobility, turning and repositioning while in bed and while seated in the wheelchair, used a walker when in the room and short distances and at all other times used a wheelchair. The plan also indicated the resident required no set-up help and walked independently in room and corridor without a mobility aid. The plan identified the resident was high risk for falls, used a rollator walker for all mobility and one staff to walk to and from meals. According to staff interviewed, the resident was independent for mobility with the use of a walker, did not require any assistance for bed mobility, did not use a wheelchair, and did not require assistance to rise from bed to a standing position except for the occasional first rise of the day.

d) Resident #600 had a physician's order for a therapeutic diet, regular texture. The nutrition assessment protocol dated January 6, 2013, indicated the resident received a different therapeutic diet. The dining serving report and the home's RD indicated the resident received another diet and the resident's care plan indicated the resident can have anything they want to eat.

e) It was observed on February 14, 2013 at 13:40 hours that resident #555 was in the

bathroom alone and transferred independently off the toilet. Staff indicated the resident was able to transfer on and off the toilet without staff assistance and that the resident had often toileted themselves. The plan of care indicated the resident required 1 staff to provide extensive assistance using weight bearing support by physically assisting to safely transfer on and off the toilet, adjust clothing, wash hands and to provide pericare. [s. 6. (1)]

2. The licensee did not ensure that there was a written plan of care for each resident that set out the planned care for the resident.

a) Staff interview and progress notes/occurrence reports reviewed identified that resident #777 used a protective device as an intervention to reduce the risk of injury due to falls. The care plan, in place at the time of a fall in 2012, did not include this intervention as part of the planned care for the resident. [s. 6. (1)]

3. The licensee did not ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

a) Resident #452 was admitted to the hospital in 2013, following an injury. The resident returned to the home following treatment a few days later. While the resident was in the hospital, a registered staff member, completed scheduled assessments of the resident for: skin (head to toe), pain, continence and "non-triggered clinical problem evaluation". The documentation completed does not mention that the resident was not in the home at the time of the assessment and was not physically observed. Interview with the RAI coordinator confirmed that the assessment forms were completed while the resident was in the hospital and that the assessment tools should not have been completed at that time. [s. 6. (2)]

4. Staff and others involved in the different aspects of care did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

a) Resident #452 returned to the home in 2013, following a hospitalization for an injury. The head to toe skin assessment and skin and wound progress note completed on their return, identified that the resident had areas of altered skin integrity on the sacrum and coccyx-bony prominences. Three days later, the skin and wound progress note identified that the resident had a dressing change to the incision line for

a large amount of drainage. Interview with staff confirmed that the initial assessment was not reflective of the incision, and not consistent with the assessment completed three days later.

b) The minimum data set (MDS) assessment completed on November 18, 2012 for resident #472 indicated the resident did not use a physical restraint and no resident assessment protocol was triggered/completed by staff. Interview with the RPN confirmed that the resident has had a physical restraint in place for approximately 1 month. [s. 6. (4) (a)]

5. Staff and others involved in the different aspects of care did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated, consistent with and complement each other.

a) The plan of care for eating created by a RPN indicated that resident #401 was independent during eating with no assistance required however, the plan of care for nutritional status created by the homes dietitian indicated the resident required feeding and total assistance. [s. 6. (4) (b)]

6. The care set out in the plan of care was not provided to the resident as specified in the plan.

a) During the afternoon shift of a specified date in 2012, resident #777 was not provided care as specified in the plan of care. The plan which was in effect on the specified date, identified the following needs for the resident:
i) that staff were to ensure that clothing was changed every day and evening;
ii) a toileting schedule including to be toileted between 18:00-19:00 and 20:00-21:00 hours;
iii) a bed alarm in place.
Three staff interviewed, who were responsible to provide care to the resident on the specified date, confirmed that the resident was not provided with evening care, despite documentation on the resident's flow sheet record. It is believed that the resident transferred independently to bed, following dinner and that aside from monitoring checks the resident was not administered care until found on the floor at approximately 22:30 hours. The resident was not changed into evening clothing, was not toileted as per the schedule and did not have a bed alarm in place when in bed.

b) The plan of care, which was in effect, for resident #777, on a specified date in 2012, identified that the resident was to "remain in bed at all times as per family request" as the resident's condition was palliative. Family have reported that the resident was up in the chair for meals on the day shift of the specified date, despite their request and interventions in the plan. Interview with an RPN, who worked the evening shift on the specified date, confirmed a discussion he had with the resident's family on that day. The family had reported that the resident was up in the chair during the day, despite their requests, and the RPN provided confirmation that staff were aware of the current needs and that the resident would remain in bed.

c) The plan of care for resident #492 identified that the resident was non-complaint in waiting for staff assistance with transfers, however staff are to provide limited assistance with toileting and transfers due to physical limitations. The resident had been identified as a high fall risk. Staff and resident interviews confirmed that the resident completed transfers and toileting independently (except at bedtime). When questioned about the care needs of the resident staff responded that they "would refuse the assistance if offered" despite the interventions on the plan to provide limited assistance - including locking of the resident's wheelchair and guiding during the activity.

d) According to the plan of care, resident #395 was identified as a falls risk. The plan indicated the resident had agreed to wear a protective device. The device was provided and staff were to apply it every morning and remove every evening. The resident was observed on February 11 and 12, 2013 without the device. Staff confirmed the resident was not using the device.

e) Resident #555 had a scheduled toileting program that indicated the resident was to be toileted between 11:00-12:00 hours. The inspector observed the resident from 10:20-12:20 hours on February 14, 2013, and the resident was not toileted during the specified time. The PSW confirmed staff did not toilet the resident during the specified time.

f) The plan of care for resident #427 indicated staff would assess skin during bi-weekly baths, document on skin flow sheets after each shower, and report changes in skin integrity to Registered Staff. In 2012, the resident was noted to have a bruise, however, there was no record of the bruise in the resident's clinical record. This information was confirmed by staff. [s. 6. (7)]

7. The resident was not reassessed and the plan of care reviewed and revised at least every 6 months and any other time when the resident's care needs change or care set out in the plan is no longer necessary.

a) The plan of care for resident #492 was not revised when the resident's care needs changed. The current plan indicates that that resident used a bed alarm. Interview with both the resident and front-line nursing staff confirmed that the resident does not use a bed alarm.

b) The plan of care notes that resident #443 used a chair alarm and a front fastening seatbelt when in the wheelchair. Staff interview and resident observation confirmed that the resident does not have a chair alarm only a specified physical restraint when up in the wheelchair.

c) Resident #452 returned from the hospital following surgery. The plan of care, which was reviewed a few weeks later, identified that the resident was independent with toileting, transfers and fully continent. Interview with the resident and staff on two shifts confirmed that the resident required staff assistance with these activities of daily living and incontinent of bladder. Interview with the RAI coordinator on February 14, 2013 confirmed that the plan had not been revised by nursing since return from hospital.

d) According to the plan of care, resident #395 wore large pull-ups during the day and a yellow brief at night. Staff interviewed reported the resident wore full briefs and had not used pull-ups for sometime.

e) According to staff interviewed, resident #267 was bed fast and receiving end of life care. The plan of care related to activities of daily living (eating, transferring, toileting, bathing) and recreation was not updated to reflect the change in the resident's condition.

f) Resident #401 recovering from pneumonia, malnourishment and mild dehydration was seen by the home's nurse practitioner. Following this visit there was a physician's order to have the dietitian assess the resident and increase protein however; there was no assessment or protein added to the resident's diet as recommended. The following day, the RD assessed the resident for a diet texture

change however did not assess protein or hydration status at that time. The RD confirmed she was unaware of the order and did not reassess the resident or revise the plan of care despite changes in the resident's condition. [s. 6. (10) (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 compliance related to LTCHA, 2007 s. 6(1), 6(2), 6(4), 6(7) and 6(10), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee of the home did not ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with.

a) The home policy "Assessment Admission/Quarterly", number 03-04, directs staff to assess residents as follows "upon return from hospital or a leave of absence greater than 24 hours the resident will have a head to toe skin assessment completed and documented on the shift which they return to the home".
Resident #452 returned from hospital. A review of the clinical record and interview with staff confirmed that the resident did not have a head to toe assessment documented until the resident was back in the home for 2 days.

b) The home has a procedure in place directing staff to monitor the vital signs of residents called "Vital Signs Introduction", policy number 07-01. This procedure directs staff to complete a full set of vital signs to include temperature, pulse, respiration and blood pressure on every shift for 72 hours on admission and following return from hospital.
i) Resident #777 returned from the hospital. A review of the clinical record identified that staff did not document the vital signs for 72 hours following this readmission from the hospital.
ii) Resident #452 returned from the hospital on two occasions. A review of the clinical record identified that staff did not document the vital signs, on a consistent basis, for 72 hours following readmission from the hospital on either occasion.
iii) Resident #395 returned to the home following two hospital admissions; vital signs, including temperature, pulse, respiration and blood pressure were not consistently recorded on each shift for 72 hours.
iv) Resident #502 was admitted in 2012, however, vital signs were not consistently monitored on each shift for 72 hours.
v) Resident #401 returned from hospital, however vitals were only taken upon return, on three occasions. Registered staff confirmed that vitals were not completed every shift for 72 hours following the resident's return from hospital

c) The home has a policy "Bathing", procedure 05-65. This procedure indicates "upon admission, the Registered Staff member will ask the resident/incapable resident's SDM about his/her bathing preferences including type, frequency, and timing of the bath. Considers the appropriateness of the resident's request in keeping with the resident's safety and hygiene needs. Organizes a bathing plan accordingly, documenting this in the residents progress notes and on the resident's plan of care".

i) Resident #501 was admitted in 2013 and resident #502 was admitted in 2012; neither resident's bathing preference was documented in the progress notes after their admission.

d) Staff stated that the home's bowel protocol requires after 3 days with no movement to administer prune juice/fruit rite; 4 days with no movement administer a suppository and after the 5th day repeat suppository or fleet enema.
i) Bowel records indicated that resident #472 did not have a bowel movement from February 8-13, 2013. Multidisciplinary notes dated February 11, 2013 indicated that fruit rite was provided at breakfast on the 4th day with no movement however; the medication administration record (MAR) and notes indicated that there were no further interventions provided until the sixth day when a suppository was provided.
ii) Bowel records indicated that resident #600 did not have a bowel movement January 31- February 3, 2013. The multidisciplinary notes dated February 3, 2013 indicated that oncoming day staff would be advised of the resident's need to be provided interventions for no bowel movement for 3 days however, the MAR and the notes indicated that no treatment was offered. Bowel records indicated that the resident did not have a bowel movement from February 4-10, 2013. A multidisciplinary note dated February 9, 2013 indicated the resident refused a suppository and told staff they had a bowel movement on February 7, 2013, and indicated that oncoming staff would complete a bowel assessment and provide interventions as required. The MAR indicated the suppository was provided February 8, 2013 and was ineffective however; there was no documentation that indicated a bowel assessment was completed and interventions were provided. Staff confirmed that interventions should have started February 7th and continued when interventions on February 8, 2013, were ineffective. [s. 8. (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 policies and procedures which are instituted or otherwise put in place are complied with, to be implemented voluntarily.

WN #5: 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 did not ensure that there was a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.
i) On February 6, 2013, the call bell in resident room #1100 was observed behind the resident's night stand rendering it inaccessible for use. On February 19, 2013, the call was observed in the same location.
ii) On February 6, 2013, the bathroom call bell in room #2092 was tied around the grab bar next to the toilet, rendering it inoperable.
iii) On February 5, 2013, the call bell cords in residents #455, #459, #472, #478, #480 and #555's bathrooms were wrapped around the bars, rendering them inoperable.
iv) On February 6, 2013, the call bell cords in residents #425 and #426's bathrooms had a zip tie attached however; the cords were wrapped around the bars and would only activate when pulled in a specific location.
v) The call bell cord in the Montebello spa room was wrapped around the bar and did not activate when pulled, unless the cord was pulled above the level of the bar. Staff confirmed that it did not activate when pulled.

Several staff interviewed confirmed that to activate the call bells the cord had to be pulled at the top which would not be accessible to the resident when using the toilet. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the resident-staff communication and response system is easily seen, accessed and used at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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 did not ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

a) Managers and front line staff interviewed confirmed that the home does not have current policies and procedures available reflective of current practice, specifically "Point of Care" documentation related to skin, activities of daily living, restraint use and food and fluid intake.

b) Staff interviewed reported that staff are required to record bruises and skin tears in progress notes, however, the home did not have a policy or procedure that directed staff to record and monitor bruises or skin tears.
i) Resident #387 sustained a skin tear measuring 3.5 x 2.0 cm. According to the treatment administration record (TAR), dressings were changed on four occasions, however, there was no record of how the resident sustained the skin tear, nor was there any record of a description of the area, despite the resident being bedridden and totally dependent on staff for all aspects of care.
ii) Resident #427 was noted to have a bruise, however, there was no record of the bruise in the resident's clinical record. [s. 30. (1)]

2. The licensee did not 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.

i) Resident #401 had prescribed snacks in the afternoon and before bed however, consumption of the resident's before bed snack was not recorded from January 5-February 1, 2013 and the dietitian confirmed that the effectiveness of the intervention had not been evaluated as a result.
ii) Resident #401 was to receive treatment two times a day however; there was no documentation on the treatment administration record that the treatment was provided on 11 occasions from January 1-January 15, 2013 and 21 occasions for the month of December 2012. Staff confirmed that treatments were not documented as provided. [s. 30. (2)]