Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 22, 2016	2016_463616_0008	001853-16	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF THUNDER BAY
c/o Dawson Court 523 Algoma Street North THUNDER BAY ON P7A 5C2

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

PIONEER RIDGE
750 TUNGSTEN STREET THUNDER BAY ON P7B 6R1

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

JENNIFER KOSS (616)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 6, 7, 8, 2016

This complaint inspection was related to a concern that residents' call bells were not within reach, in addition, a complaint intake was inspected related to improper care and neglect from nursing staff.

Critical Incident inspection #2016_463616_0009 and Follow Up inspection #2016_463616_0010 were also conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator (AD), Director of Nursing (DON), Clinical Managers, Registered Dietitian (RD), RAI Coordinator, Personal Support Workers (PSW), Best Practice Coordinator, family members, and residents.

Observations were made of the home areas, and the provision of care and services to residents during the inspection. Many of the home's policies and procedures, and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A complaint was received by the Director via the ACTIONline in February 2016, regarding resident #002's change in weight status and improper fitting dentures.

In an interview with the complainant, they reported to Inspector #616 that the resident's dentures were observed in the resident's mouth on two dates in December 2015.

A review of the documentation on the resident's "Care Flow Sheet" indicated that oral hygiene, denture care had been provided to the resident on two occasions in one day in December, and once on two additional days in December 2015.

The Inspector reviewed a physician's order dated in December 2015, within their health

record after a change in the resident's health condition, to keep dentures out.

A progress note in December 2015, documented the resident's change in health condition with instruction to not put their dentures in.

The Inspector reviewed the Treatment Administration Record (TAR) which instructed staff to "keep dentures out", effective after the change in their health status.

The care plan in effect at the time of the resident's change in health status was reviewed by the Inspector and had not been updated to include the change in use of dentures. It instructed staff that resident #002 had dentures and needed assistance from staff to clean and remove the dentures at bedtime.

During an interview with the Best Practice Coordinator, they stated this care plan was current and in effect at the time of the resident's change in health status, and denture care had not been updated. In an interview with Clinical Manager #104, they stated the plan of care did not provide clear direction for staff related to resident #002's denture care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A skin assessment was completed in December 2015 that identified more than one area of altered skin integrity on resident #002.

Inspector #616 reviewed an order which included the frequency of treatment for one of areas of altered skin integrity. The prescriber had also noted an additional area of altered skin integrity. The resident's Treatment Administration Record (TAR) included the treatment orders for both areas, as well as assessment of the additional area to have been completed daily.

Over a three day period in December 2015 there was no documentation on the TAR, or within progress notes, that the treatment orders for either area had been provided as indicated in the resident's plan of care.

The home's policy titled "Skin Care and Wound Management Program", last revised January 2015, directed that each resident's treatment plan shall be carried out. The policy further stated that all skin assessments were to be documented in the progress

notes.

During an interview with Clinical Manager #104 and the Best Practice Coordinator, they stated that staff documented the administration of wound/skin treatments in the TAR, and wound/skin assessments in the progress notes. Both stated they would have expected to see documentation of the daily assessment in the progress notes. With the lack of documentation, neither could confirm wound care had been provided as ordered for the resident's two areas of altered skin integrity. [s. 6. (9) 1.]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change.

A complaint was received by the Director via the ACTIONline in February 2016, related to neglected nutrition and hydration needs of resident #002 by nursing staff.

In a progress note in December 2015, within the resident's health record, the physician had indicated resident #002's change in condition. According to additional progress notes reviewed by Inspector #616, the resident required specific medical attention. The care plan in effect prior to the change in condition was reviewed by the Inspector related to an activity of daily living (ADL). This care plan provided staff instruction related to the needs of the resident for this ADL.

Documentation on the "Resident Care Flow Sheets" early in December 2015, indicated to the Inspector that the resident had received a specific level of care related to this ADL prior to their change in condition.

The Inspector also reviewed the care plan related to this ADL in effect after the change in condition, which indicated the resident's diet, texture type, fluids consistency, and medication administration method. In this care plan, there was no intervention for the level of ADL assistance that the resident required.

The "Resident Care Flow Sheets" were reviewed by the Inspector for late December which indicated that the resident received an elevated level of assistance with this ADL. However, documentation over a 10 day period revealed inconsistencies related to the level of assistance provided by staff.

During interviews with the Registered Dietitian (RD) and Clinical Manager #104, they

stated that the resident's ability and required level of assistance during this ADL should have been reassessed when their needs had changed. They stated that resident #002's plan of care had not been reviewed and revised to reflect the change in the resident's assistance level required from staff. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to residents related to dental care, to ensure that the provision of the care set out in the plan of care is documented related to skin and wound treatments and assessments, and to ensure that residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change related to activities of daily living, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place a policy, the policy was complied with.

A complaint was received by the Director via the ACTIONline in February 2016, related to neglected nutrition and hydration needs of resident #002 by nursing staff.

Inspector #616 reviewed the home's "Hydration Program", last revised June 2015, which stated the "Food and Fluid Intake Record" was to be utilized for tracking of all resident fluid intake to support risk identification and monitoring of resident hydration. It further stated that unless otherwise ordered, any resident with fluid intakes of less than 1100 millilitres per day (mls/per day) (ie. 75 per cent of 1500 mls minimum) for three consecutive days, it was to be reported by the Personal Support Worker (PSW) to the RPN. The RPN would document on the progress notes and report to Registered Nursing (RN). The RN would assess the resident for dehydration, monitor and record strict fluid intake for an additional 24 hours, and ensure strategies to increase fluid intake from the Nutrition Care Plan were being implemented. If fluid intake continued to be less than 1100 mls/day, RN would refer to the RD, the RN (EC) and/or the physician (MD) as required.

The Inspector reviewed resident #002’s "Solid Food and Intake Sheet" for three months. In the first month reviewed, for five consecutive days the resident’s daily fluid intake totals were less than 1100 mls/day.

Inspector #616 reviewed progress notes from this five day period, and noted that 19 days later a registered staff documented that the resident had a change in nutrition status, left a note for the physician, and sent a referral to the RD.

During interviews with the RD and Clinical Manager #104, the RD confirmed as per an assessment dated two months prior, that the resident's nutrition risk had been determined as evidenced by, but not limited to, potential for inadequate intake. Both stated that according to the home's policy, the RD should have received a referral when the resident's intake was documented less than 1100 mls/day for three consecutive days but had not. [s. 8. (1) (a),s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a Hydration Program policy, ensure that the policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers had been reassessed at least weekly by a member of the registered nursing staff.

Inspector #616 reviewed a skin assessment within resident #002's health record completed when they had returned from hospital. On this assessment, two areas of altered skin integrity were identified.

The home’s policy "Skin Care and Wound Management Program", last revised January 2015, was reviewed and directed that each resident who exhibited skin breakdown and/or wounds was to be assessed each week or more frequently, if needed, by a member of the registered nursing staff. It further stated, all skin assessments were documented in the progress notes.

One area of altered skin integrity was documented on the home's "Wound/Skin Assessment", however the Inspector found no "Wound/Skin Assessment" for the other area of altered skin integrity.

The Inspector reviewed the resident's progress notes related to wound/skin assessments. During two weeks, no weekly wound/skin assessments were completed for either of the two areas of altered skin integrity.

During an interview with Clinical Manager #104 and the Best Practice Coordinator, they stated that the weekly wound/skin assessments should have been documented on the "Wound/Skin Assessment", as well as within progress notes. They verified that weekly wound/skin assessments for the two areas of altered skin integrity had not been completed as required during the two week period. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: 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 home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

During Inspector #616's interview with a complainant, they reported that residents’ call bells were not within reach.

The Inspector observed seven residents within the home areas over the inspection period. Resident #004, one resident of the seven, was observed lying in bed with their eyes closed, and a partial bed rail used. The call bell cord was hanging along the wall to the floor with the push button device underneath the bed.

PSW #101 entered the room and was asked by the Inspector if the resident used their call bell. The PSW reported the resident did use the call bell, and looked at it hanging to the floor. They added that the call bell was supposed to be on the bed rail for the resident. Without adjusting the position of the call bell to be within reach of the resident, they left the room. The Inspector remained in the resident’s room for a few minutes when PSW #103 entered. They too stated the resident used their call bell to alert staff, and proceeded to pull the call bell cord from under the bed and attached it to the bed rail. They stated it should have been in place so the resident could reach it.

The resident's current care plan identified the resident was at high risk for falls with an intervention to ensure the call bell was always within reach. [s. 17. (1) (a)]

Issued on this 5th day of August, 2016

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

Original report signed by the inspector.