Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 24, 2016	2016_289550_0009	006349-15, 023138-15	Complaint

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET OTTAWA ON K1N 5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA OTTAWA ON K1C 2Z6

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

JOANNE HENRIE (550)

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): February 2, 3, and 4 2016.

Log #006349-15 is a complaint inspection related to personal care, oral care, bathing and hygiene.
Log #023138-15 is a complaint inspection related to personal care, dining and snacks service and continence care.

During the course of the inspection, the inspector(s) spoke with the Administrator/Clinical Manager, the Director of Care/Clinical Manager, Registered Nurses
(RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and several family members.

In addition, the inspector reviewed resident health care records and observed care and services, staff and resident interaction and meal services.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. (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. 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.

This inspection was related to complaint log #023138-15.

Resident #002 was admitted to the home in 2012 and requires the assistance of staff for all activities of daily living.

During an interview, a member of resident #002's family indicated to Inspector #550 the resident often has his/her hands soiled with feces because of the resident trying to remove his/her incontinence product. The PSW's used to dress the resident in a special type of clothing under bedclothes at bedtime to prevent the resident from accessing his/her incontinence product. The resident's family member indicated this is no longer being done as the special type of clothing have disappeared and they were not replaced by the home. Staffs are now putting another piece of clothing under the resident's bedclothes to prevent him/her from accessing his/her incontinence product.

PSW #S102 indicated to the inspector the resident no longer wears the special type of clothing as they are no longer available; they have been putting another piece of clothing

to the resident under his/her bedclothes at night.

The inspector reviewed the resident's plan of care in place dated a specific date in September 2015 and observed it is documented under Dressing "remove the special type of clothing every morning and put on at night". Under Agitated behaviour and inappropriate socially it is indicated "plays in his/her feces, don on the special type of clothing night and remove on days".

A sheet of paper dated a specific date in November 2014 signed by the Director of Care at the time and the resident's family member was observed on the resident's bedroom door. This sheet titled "Addenum au Plan de Soins du Résident #002" offers guidelines to staff on how to care for resident # 002. It indicated to remove the special type of clothing in the morning and to put it on at bedtime. The same sheet of paper was found with the resident's flow sheets in a binder in the report room as well as a note indicating the same was handwritten on the white board in the report room.

During an interview, the Director of Care/Clinical Manager indicated to the inspector staff are no longer using the special type of clothing as they are missing. They are using another piece of clothing to prevent the resident from accessing his/her incontinence product and getting his/her hands soiled with feces.

As such, the written plan of care for resident #002 does not set out the planned care for the resident. [s. 6. (1) (a)]

2. The licensee has failed to 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 care set out in the plan has not been effective.

This inspection was related to complaint log #006349-15.

During an interview, resident #001's spouse indicated to Inspector #550 that the resident is not receiving assistance to brush his/her teeth; the spouse has to do it for the resident when he/she visit.

Inspector #550 reviewed resident #001's plan of care dated a specific date in November 2015 and observed documented for dental care:
-daily cleaning of teeth or dentures, or daily mouth care by client or staff

During an interview, PSW #S100 indicated it is very difficult to brush the resident's teeth properly as he/she gets easily angry and that he/she will not always let staff do it, the resident often refuses.

Inspector #550 revised resident #001's flow sheets for oral hygiene/denture care and observed documentation as follows:

November 2015: received oral hygiene/denture care on 15 out of 15 documented day shifts and on 27 out of 27 documented evening shift (no documentation for remaining shifts for days and evenings)

December: the resident refused 30 out of 31 documented shifts for days and refused 31 out of 31 documented shifts for evening

January: refused on 22 out of 23 documented day shifts and refused 30 out of 30 documented evening shifts (no documentation for remaining shifts for days and evenings)

February (1 to 4): received oral hygiene/denture care on 1 out of 1 documented day shift and 1 out of 1 documented evening shift (no documentation for the 2 other days, day and eve).

As such, resident #001's plan of care was not reassessed and his/her plan of care reviewed and revised when the care set out in the plan has not been effective for his/her oral hygiene/dental care. [s. 6. (10) (c)]

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 resident #002's plan of care is revised to indicate the planned care for this resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 received individualized personal care, including hygiene care and grooming on a daily basis.

This inspection was related to complaint log #006349-15.

Resident #001 was admitted to the home in 2014 and according to the resident's spouse, the resident is totally dependent of staff for his/her care and hygiene. During an interview, the resident's spouse indicated to Inspector #550 that he/she visits his/her husband on a daily basis at lunchtime. Often he/she will find that his/her spouses' hands are dirty with food from the previous meal as the resident often eats with his/her hands. The resident's spouse indicated staff will not take the time to wash the resident's hands after meals and that he/she has to do this when he/she comes in at lunchtime.

A revision of resident #001's care plan dated a specific date in November 2015 indicated for personal hygiene:

-total dependence for personal hygiene;
-brush hair in am and after daytime nap,
-encourage client to participate during care to promote independence, have client wash own hands and face;
-staff to comb hair, clean nails, shave daily;
-fingernails cleaned and trimmed weekly on bath day - likes fingernails short/long, nail polish;
-staff need to explain to him/her step by step what they are going to do;
-two staff physical assistance for personal hygiene.

During an interview, PSWs staff #S100 and #S101 indicated that resident #001 is totally dependent of staff for his/her personal hygiene due to cognitive impairment. The resident can be resistive at first but he/she will accept the care when talked to and some coaxing. PSW #S100 indicated the resident will refuse nail care but they wash his/her hands after each meal.

Inspector #550 observed resident #003 in bed at 9:55 in the presence of PSW #S100 after he had indicated to the inspector he had completed the resident's personal hygiene earlier. The inspector and the PSW observed that the palm of both hands and around the nails were dirty with dry crusted food debris. The PSW indicated he did not see this and proceeded to clean the resident's hands with a facecloth. [s. 32.]

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 resident #001's hand are cleaned after each meals, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 is bathed, at a minimum, twice a week by the method of his choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

This inspection was related to complaint #006349-15.

During an interview, resident #001's spouse expressed to Inspector #550 his/her concerns regarding the care of his/her spouse. He/she indicated to the inspector the resident was not bathed twice per week and is never bathed in a tub or shower, he/she is always given a bed bath.

PSW #S100 and #S101 who are regular staffs on the unit and assigned to care for resident #001, indicated to the inspector the resident is scheduled to receive his/her bath on 2 specific days during the day. They both indicated the resident sometimes refuses and the documentation of the bath is done in the resident's flow sheet. PSW #S100 indicated he always gives a shower to the resident and sometimes the resident will refuse at first but he is able to persuade him/her with talking and much coaxing.

The Administrator/Clinical Manager indicated to Inspector #550 her expectation is that every resident receive a bath by the method of his /her choice twice per week as documented in the resident's care plan. She indicated documentation of the baths is done in the resident's flow sheet and an "R" indicates the resident's refusal.

A revision of Resident #001's plan of care dated a specific date in November 2015 indicated for bathing and shampooing:
-total dependence for bathing,
-encourage client to participate during care,
-linen changes,
-use soap and shampoo of client's choice,
-two staff physical assist for bathing,
-tub bath,
-A.M. Care,
-shower.

Inspector reviewed resident #001's flow sheets and observed documentation as follows:

November 2015: the resident received 4 out of 8 scheduled baths all documented as tub baths
December 2015: the resident received 5 out of 9 scheduled baths documented as bed baths
January 2016: the resident received 9 out of 9 baths documented as 7 bed baths and 2 tub baths
February 2016: the resident received 0 out of 1 scheduled bath.

As such, resident #001 is not bathed twice a week by a method of his/her choice. [s. 33. (1)]

Issued on this 24th day of March, 2016

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

Original report signed by the inspector.