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

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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
Jul 29, 2016	2016_289550_0023	010582-16	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): June 21, 22, 27, 28, 29, 30, July 4, 5, 6, 7 and 8, 2016.

This complaint inspection is related to a complaint regarding personal support services and continence care.

Other logs inspected at the same time of this inspection: Log #008860-16, #008256-16, #013692-16, #021122-15 and #022499-15.

During the course of the inspection, the inspector(s) spoke with The Executive Director, the Administrator/Clinical manager, the Director of Care, the Clinical Educator, the Environmental Supervisor, the Dietary manager, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), resident and family.

In addition, the inspectors reviewed resident health care records and the home's complaint policy. Inspector observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Medication
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **6 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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and a response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation commenced immediately.

Log #022499-15

On July 18, 2015, in an email communication from the night nursing supervisor #236 addressed to the Executive Director, the Administrator/Clinical Manager, the Director of Care and copied to three other staff members, it was documented that Resident #039 was unsatisfied with care and services received, including a complaint about lack of food served at dinner during the evening meal service of July 17, 2015 and feeling hungry,

and that staff ignored him/her. The resident also requested as part of the complaint to the nursing supervisor, access to his/her health record. The documentation specified that the nursing supervisor contacted the RN on duty to ensure food be immediately provided to the resident on July 17, 2015 and explained that access to health record could not be provided as it was the weekend. The resident also made a request to speak with the Executive Director to discuss his/her complaints but was never contacted or received a response by the Executive Director.

Log #010582-16

On May 29, 2016, resident #001's daughter sent an email to the Director of Care requesting to change physician as she is dissatisfied with the medical physician service currently provided.

On June 16, 2016, resident #001's daughter emailed the Administrator/Clinical manager and copied the Director of Care informing them that on June 14, 2016 at lunchtime there were issues with the meal service. On June 11 and June 15, resident #001 was in the dining room sitting at her table with fecal matter on a specific body part and personal belongings. On June 15, 2016 resident #001 was observed in the hallway at 1455, therefore had not been put to bed after the meal as per the plan of care.

Later that same day, resident #001's daughter emailed the Administrator/Clinical manager and copied the Director of Care, the Executive Director and his administrative assistant with concerns she had brought to the attention of the Executive Director during two meetings with him in May 2016. She informed them that families will not accept that a resident be force-fed, a resident with abdominal pain is not brought to the toilet or put to bed to relieve his/her pain and that a resident is not well positioned in his/her wheelchair. She informed them that part-time staff who don't know the residents, don't consult the resident's kardex therefore not follow the residents' diets which could be very dangerous to a resident's health. The Executive Director responded indicating he would be looking into the issues, but no further response from the home after this.

Log #013692-16

On April 11, 2016, resident #002's daughter and substitute decision maker informed the Administrator/Clinical manager that the resident was given fish to eat on Wednesday April 11 and that it is indicated on resident #002's kardex that he/she does not like fish. She also informed her that a female resident wanders in resident #002's room. The

resident's daughter did not receive any response from the Administrator/Clinical manager.

On May 19, 2016, resident #002's daughter informed the Administrative assistant of concerns she was having who in turn emailed the Executive Director and copied the Administrator/Clinical manager. Her issues were that resident #002's bed sheets had not been changed in over a week, she would like for staff to remove the mesh sling from under the resident after the resident is transferred to the wheelchair and that when she asked staff they replied that they don't do this for any other residents so shy would they do this for her. She has to transfer resident #002 to bed while staff are sitting in the lounge and she has previously complained about a broken picture frame, missing socks and broken eyeglasses for which she is still upset about.

Upon a review of the home's Complaints Tracking Spreadsheet, Inspector #550 observed there was no evidence that the home had conducted an investigation, resolved the issues where possible, or provided a response within 10 business days of receipt of the complaint to resident #001's daughter. The Director of Care indicated she emailed the home's advisory physician the following day with the request and had not received an answer. On June 29, 2016, she emailed him again and this time he responded he would look into the issue and informed her the request had ''fallen off his radar''.

In discussion with the Administrator/Clinical Manager, she indicated that the Executive Director was no longer an employee of the home and she was unable to find any documented investigation, resolution and/or response provided to resident #039, resident #001's daughter and resident #002's daughter regarding their complaints.

Inspectors #545 and #550 reviewed the home's Complaints Tracking Spreadsheet and observed there was no indication to demonstrate that the home had conducted an investigation, resolved the issues where possible, or provided a response within 10 business days of receipt of the complaints to resident #039 and resident #001 and #002's family member. [s. 101. (1) 1.]

2. The licensee has failed to ensure that documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required

(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

In discussion with the Administrator/Clinical Manager she indicated that the home's Complaint Tracking Spreadsheet has been used to track complaints up until spring 2016 when the home adopted the RIMS system.

The home's Complaints Tracking Sheet was reviewed by Inspector #545. The electronic spreadsheet was set up with several columns, such as:
-Date Complaint Received
-Name of Service / Unit involved
-How was the complaint logged (phone, writing, person)
-Complaint received by Summary of Complaint
-Follow-up done by and date
-Complainant's name
-Complainant's contact Information
-Complainant's relationship to patient
-Complaint Status Active or Closed
-Documentation (attached documents)

Log #021122-15

On July 16, 2016 a verbal complaint was received by resident #040's daughter related to staff not providing a wheelchair and administering oxygen to the resident as required. The daughter added, in speaking with Inspector #550 that she had requested to speak directly with the Executive Director and that she did not receive a response.

Upon review of a LTC Complaint Tracking Form completed by the Administrator/Clinical Manager, it was documented that resident #040's daughter was contacted on July 17, 2015 to follow-up on part of the complaint. The home was unable to provide evidence of documented record of having provided the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant.

Log #022499-15

On July 18, 2015 in an email communication from the night nursing supervisor #236 addressed to the Executive Director, the Administrator/Clinical Manager, the Director of Care and copied to three other staff members, it was documented that Resident #039 was unsatisfied with care and services received, including a complaint about lack of food served at dinner evening of July 17, 2015 and feeling hungry, and that staff ignored him/her.

Log # 010582-16

On May 29, 2016, resident #001's daughter sent an email to the Director of Care requesting to change physician as she is dissatisfied with the service currently provided.

On June 16, 2016, resident #001's daughter emailed the Administrator/Clinical manager and copied the Director of Care informing them that on June 14, 2016 at lunchtime there were issues with the meal service. On June 11 and June 15, resident #001 was in the dining room sitting at her table with fecal matter on a specific body part and personal belongings. On June 15, 2016 resident #001 was observed in the hallway at 1455, therefore had not been put to bed after the meal as per the plan of care.

Later that same day, resident #001's daughter emailed the Administrator/Clinical manager and copied the Director of Care, the Executive Director and his administrative assistant with concerns she had brought to the attention of the Executive Director during two meetings with him in May 2016. She informed them that families will not accept that a resident be force-fed, a resident with abdominal pain is not brought to the toilet or put to bed to relieve his/her pain and that a resident is not well positioned in his/her wheelchair. She informed them that part-time staffs, who don't know the residents, don't consult the resident's kardex therefore not follow the residents' diets which could be very dangerous to a resident's health.

Log #013692-16

On April 11, 2016, resident #002's daughter and substitute decision maker informed the Administrator/Clinical manager that resident #002 was given fish to eat on Wednesday April 11 and that it is indicated on resident #002's kardex that he/she does not like fish. She also informed her that a resident wanders in the resident's room. On May 19, 2016, resident #002's daughter informed the Administrative assistant of concerns she was having who in turn emailed the Executive Director and copied the Administrator/Clinical manager. Her issues were that resident #002's bed sheets had not been changed in over

a week, she would like for staff to remove the mesh sling from under the resident after the resident is transferred to the wheelchair and that when she asked staff they replied that they don't do this for any other residents so shy would they do this for resident #001. She has to transfer the resident to bed while staffs are sitting in the lounge and she has previously complained about a broken picture frame, missing socks and broken eyeglasses that she is still upset about.

The Complaints Tracking Spreadsheet was reviewed; there was no evidence of documented record for these complaints. The home was unable to provide evidence of documented record of having provided the final resolution, if any, every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant. [s. 101. (2)]

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 every written or verbal complaint concerning the care of a resident or operation of the home is investigated, resolved where possible and a response provided within 10 business days of receipt of the complaint and that the home keeps documented records of such complaints as per O. Reg 79/10, s. 101. (2), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies, equipment and devices are readily available to meet the nursing and personal care needs of the resident.

On June 27, 2016 at 1640hrs, Inspector #550 was approached by the son of resident #001 and informed that the staff did not have access to a mobile lift to get the resident up

and ready for dinner. He indicated that the ceiling lift in resident #001's room had been removed earlier that day as the track was determined to be unsafe for use during an audit by Biomed. Inspector interviewed the PSW who was in the room at the time and was informed that they could not find a mobile lift to get the resident up for dinner. RN staff #S108 who was the RN in charge at that time indicated to the inspector she was just made aware that 8 ceiling track lifts were removed from residents' room after an audit was performed on the ceiling lifts that afternoon. She indicated that PSWs went to the other floors/units (units 2C and 4th floor) in search of a mobile lift but were unable to find one they could use as they were all being used by the other floors. At 1720hrs, staffs had found a mobile lift from another floor and were able to get the resident up for dinner. On June 28, 2016 the son of resident #001 informed the inspector that the staff informed him that they did not have a lift to get resident #001 up for breakfast. The son was upset that he had to insist that they find a mobile lift to get the resident up. The resident was up for breakfast at 0815hrs on that day. On June 29, PSW #S109 indicated to the inspector that resident #013 was not up for breakfast because they did not have a mobile lift available on their unit to get the resident up and that they had no time in the morning to run to the 4th floor to get a mobile lift. RPN #S106 indicated to Inspector #550 that resident #012 was not up for breakfast and lunch on June 29 and 30th and resident #001 was not up on June 29 for breakfast as there were no mobile lifts available on the unit to get the two residents up. The RPN also indicated that staff did not have the time to go on other floors/units to search for a mobile lift.

On June 28, 2016 Inspector #550 interviewed the DOC and she indicated she was informed that morning that 8 ceiling track lifts in 8 rooms were in disrepair. She indicated that the home was making arrangements with a sister home to borrow two mobile lifts from them until their ceiling track lifts were repaired. She indicated there should be a process in place to ensure that mobile lifts are readily available when the ceiling track lifts are in disrepair.

On June 29, 2016 during an interview, the Executive Director indicated that the home has a contract with Biomed to do preventative maintenance on their ceiling track lifts and that during their audit, they found some lifts to be in disrepair. He indicated there was no process in place to ensure that mobile lifts are readily available to staff when the ceiling track lifts are in disrepair. He indicated that arrangements to borrow mobile lifts were being made with a sister home and will be sent to this home.

On July 4, 2016 the DOC indicated to the inspector that all the ceiling track lifts were repaired and functional on June 30th, 2016 at 1800hrs.

As evidenced above, the licensee did not ensure that equipment and devices were readily available to meet the nursing and personal care needs of resident #001, #012 and #013. [s. 44.]

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 mobile lifts are readily available at the home for use when ceiling tracks are defective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal.

On June 30 2016, at 0830hrs, Inspector #550 observed on the 2AB unit dining room at the table where resident #006 is expected to sit, there was a bowl of Rice Crispy cereal, a plate with a cut-up banana, one container of yogurt, one glass of milk, one glass of orange juice and one glass of water. The resident was not in the dining room. On the table next to the wall where resident #007 is expected to sit, there was a bowl of Rice Crispy cereal, a plate with a cut up banana, one container of yogurt, two glasses of milk and one glass of orange juice. The resident was not in the dining room.

The breakfast menu posted for that day indicated:
Stewed prunes - mandarins, hot and cold cereals, variety of toasts, cheese and muffin.

On July 5, 2016, Inspector #550 observed the meal service in the 2AB unit dining room at 0805hrs and observed the following:

-at the table where resident #012 is expected to sit, there was a glass of water, a glass of orange juice, an opened container of yogurt, a glass of milk and a bowl of Cornflakes cereal with sugar. The resident was not present; he/she arrived 10 minutes later. When the resident was done eating his/her cereal, a PSW brought toasts and eggs to the resident without offering.
-at the table where resident # 007 is expected to sit, there were two glasses of milk, a glass of orange juice, a glass of water, a container of yogurt, a bowl of Cornflakes cereal with sugar. The resident was not there.
-at the table where resident #014 is expected to sit, there was a bowl of Cheerios, two glasses of milk, one glass of orange juice, a glass of water and an opened container of yogurt. The resident was not present. At the same table, where resident #015 is expected to sit, there was a glass of orange juice, a glass of water, a glass of milk, an opened container of yogurt and a bowl of Cheerios cereal. The resident was not present.

-at the table where resident #016 is expected to sit, there was a bowl of Cheerios cereal, a glass of milk, a glass of water, a glass of orange juice and an opened container of yogurt. When the resident was done eating his/her cereal, PSW #S103 indicated to the dietary assistant that the resident was ready for toasts and brought the resident toasts. The resident was later offered another toast but was never offered eggs.
-when resident #017 was done eating the cereal, PSW #S103 brought the resident toast and eggs. This was not offered to the resident.
-toast were brought to resident #018, eggs were not offered.
-at the place where resident #006 is expected to sit, there was a bowl of Cornflakes cereal, a glass of milk, a glass of water and a glass of orange juice. The resident was not present. Toast were later brought to the resident but no eggs offered.
-at the table where resident #019 is expected to sit there was a bowl of oatmeal, a container of yogurt, a glass of thickened orange juice, a glass of thickened water and stewed prunes. The resident was not there, he/she arrived 10 minutes later. After the resident was done eating the oatmeal, the resident was not offered toast or eggs.
-resident #001 was given toast when he/she was done eating cereal, eggs were not offered to the resident.

The posted menu for that day indicated:
Stewed prunes, mandarins, hot/cold cereals, variety of toast, scrambled eggs.

During an interview on June 30th, 2016, PSW #S103 indicated to the inspector that bananas, yogurt, cereals and juices are always put on the tables before the residents arrive in the dining room as they know what the residents like to eat.

The food attendant staff #S105 indicated to the inspector that she puts bananas, yogurt, cereals and liquids on the tables in the dining room before the residents are seated at their table as she knows what the residents like to eat and she does not have the time to offer the planned menu. She has to do this because the PSWs are busy getting the residents up for breakfast and most of the time she is alone to serve all the residents. The food attendant stated she has to leave the unit at 0905hrs with the meal cart and return to the kitchen. Therefore, all the residents have to be served by that time.

During an interview, the nutritional manager and the dietician both indicated to the inspector that the residents are to be offered the planned menu at breakfast and that this is a problem on the 2AB unit.

As evidenced above, the residents on the 2AB unit dining room are not offered the planned menu items at each meal. [s. 71. (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 residents are offered planned menu items at each meal, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that there were written complaint procedures in place that incorporated the requirements set out in section 101 for dealing with complaints.

Complaints and Concerns from Patients and Family, policy number ADMIN 02 (revised

June 2015) was provided to Inspector #550 by the Administrator/Clinical Manager upon request for the home's complaints policy.

A review of the Complaints policy demonstrated that the policy did not incorporate the following requirements set out in section 101 for dealing with complaints:

O. Reg. 79/10 s. 101 (1) indicates that every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately;

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances;

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, as defined by O. Reg. 79/10, s. 101 (1).

Items 1, 2 and 3, as stated above were missing from the home's Complaint's policy.

O. Reg 79/10 s. 101(2) indicates that the licensee shall ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant

Items c, d, e and f, as stated above were missing from the home's Complaint's policy.

The Administrator/Clinical Manager confirmed that the home's Complaints' policy was not updated, following the last Resident Quality Inspection conducted in December 2015, therefore none of the changes recommended, as per legislation, were not made. The licensee was found non-compliant and was issued a written notification (WN) during the Resident Quality Inspection (2015_289550_0027) dated January 21, 2016, for this same issue. [s. 100.]

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 the home's written complaint procedure contains all the requirements as per O. Reg. 79/10 s. 101 (1), to be implemented voluntarily.

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. (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 has failed to ensure that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance.

On June 27, 2016 at 0830hrs, Inspector #550 observed on the 2AB unit dining room at the table where resident #005 is expected to sit, a container of yogurt, a container of pureed pears, a bowl of oatmeal, one glass of red juice and one glass of water but the resident was not in the dining room. PSW #S103 indicated to the inspector that the resident was not in the dining room but staff were getting the resident up and would bring

him/her shortly. The resident arrived 10 minutes later and was assisted with his/her meal. At 1310hrs that same day, resident #005 was observed sitting in a wheelchair in the dining room. The inspector observed there was a plate of pureed food, a bowl of soup, one glass of juice and one glass of milk on the table in front of the resident and no one was there to feed the resident. PSW #S103 indicated to the inspector that PSW #S104 would feed resident #005 after done distributing the deserts to the other residents in the dining room. PSW #S104 started to feed resident #005 at 1319hrs and the resident was asleep at the dining table.

On June 30th, 2016, at 0835hrs, Inspector #550 observed resident #005 sitting in a wheelchair in the dining room. On the table in front of the resident was a plate with a cut-up banana, one container of yogurt, one container with pureed fruit, one glass of orange juice, one glass of milk, one glass of red juice, one glass of water and a waxed paper cup filled with a beige creamy liquid. No staff was present to feed the resident. A PSW arrived approximately 10 minutes later to feed the resident.

It was documented in POC resident #005's food consumption for lunch on June 27th, to be 0-25%.

A review of resident #005's plan of care dated April 18, 2016 indicated resident #005 required assistance for eating, one staff provides hands on support to eat.

On April 30, 2016 the resident's nutritional risk was assessed by the home's dietician and determined to be at high nutritional risk due to:
-severely underweight or BMI (18 in most elderly individuals),
-recent change in appetite/food intake 25% or less at 2 out of 3 meals in "observation period"/history of poor intake/ missing 2 or > food groups/ refused to eat > or equal 3 consecutive meals,
-active chronic disease or advancing dementia significantly affecting intake / missing 2 or more food groups, physical signs of malnutrition or anorexic/failure to thrive and total assistance for meals/needs extensive encouragement to eat/ severely reduced mobility/bedridden/Hx of recurrent falls.

As evidenced above, resident #005 who is at a high nutritional risk, requires assistance of staff with eating and drinking and was not served his/her meal when someone was available to provide the assistance. [s. 73. (2) (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 that resident #005 who requires assistance with eating is served a meal only when someone is available to provide the assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home are immediately forwarded to the Director.

Log #022499-15

On July 18, 2015 in an email communication from the night nursing supervisor #236 addressed to the Executive Director, the Administrator/Clinical Manager, the Director of Care and copied to three other staff members, it was documented that Resident #039 was unsatisfied with care and services received, including a complaint about lack of food served at the dinner evening meal of July 17, 2015 and feeling hungry, and that staff had ignored the resident and his/her needs.

Log #010582-16

On May 29, 2016, resident #001's daughter sent an email to the Director of Care requesting to change physician as she is dissatisfied with the service currently provided by the attending physician.

On June 16, 2016, resident #001's daughter emailed the Administrator/Clinical manager and copied the Director of Care informing them that on June 14, 2016 at lunchtime there were issues with the meal service. On June 11 and June 15, resident #001 was in the dining room sitting at the table with fecal matter on a specific body part and personal belongings. On June 15, 2016 resident #001 was observed in the hallway at 1455, therefore had not been put to bed after the meal as per the plan of care.

Later that same day, resident #001's daughter emailed the Administrator/Clinical manager and copied the Director of Care, the Executive Director and his administrative assistant with concerns she had brought to the attention of the Executive Director during two meetings with him in May 2016. She informed them that families will not accept that a resident be force-fed, a resident with abdominal pain is not brought to the toilet or put to bed to relieve his/her pain and that a resident is not well positioned in his/her wheelchair. She informed them that part-time staff, who don't know the residents, don't consult the residents' kardex therefore they do not follow the residents' diets which could be very dangerous to residents' health.

During an interview, the Administrator/Clinical manager indicated to Inspector #550 that these complaints received in the form of emails were not immediately forwarded to the Director as they were occupied with the day to day challenges in long term care. [s. 22. (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 all written complaints regarding the care of a resident or the operation of the home are immediately forwarded to the Director, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

During an interview, resident #001's daughter indicated to Inspector #550 that on June 21, 2016 she sent an email to RN #S112 and RPN #S106 requesting that specific interventions be added to resident #001's written plan of care to prevent any falls but that it was not done. The interventions were as follows:
-make sure the resident has a specific type of bag beside him/her at all times especially when the resident is in bed to prevent him/her from searching for the bag and attempt to get out of bed.
-ensure the resident's denture is placed in the yellow box and the box placed in a specific bag at bedtime
-remove and place eye glasses in a specific bag at bedtime
-place the remote control for the bed on the floor
-when resident #001 is sitting in the wheelchair in the room or hallway and there is no surveillance, the wheelchair needs to be tilted
-need to be put to bed after meals unless there is an activity
-change the resident's brief more often when the resident is frequently incontinent of stools

The inspector reviewed the resident's actual written plan of care and observed that none

of the above interventions were documented as per resident #001's daughters' request.

During an interview, the DOC indicated to the inspector that RN #S112 who is the RN in charge of the unit and to whom the email was sent is responsible for updating the resident's plan of care.

During an interview, RN #S112 indicated to the inspector that she did receive the email from resident #001's daughter on June 21, 2016 but she did not update the resident's care plan as per the daughter's request as she did not have the time to do so.

As such, resident #001's daughter was not provided the opportunity to participate fully in the development and implementation of her mother's plan of care. [s. 6. (5)]

2. 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 or care set out in the plan is no longer necessary.

During an interview, resident #001's family indicated to Inspector #550 that the resident is often incontinent of stools.

The inspector reviewed resident #001's health care records and observed documented in POC for a specific period in 2016 the resident was continent of stools only once during that period and was incontinent on all the other days.

The last continence assessment for the resident was done on December 1 2015 and indicated the resident is continent of stools.

The actual written plan of care for resident #001 indicated the resident is continent of stools and that he/she is on a bowel retraining program.

PSW #S104 who is the PSW caring for the resident indicated to the inspector that resident #001 has been frequently incontinent of stools following a fracture of a specific limb 3 months ago and that he/she wears an incontinence product. He indicated the resident is toileted on the bedpan once in the morning and once in the afternoon on day shift and he/she is almost always incontinent. Staff has to provide full pericare and change the resident's brief after each incontinence.

As such, resident #001 was not reassessed and her plan of care was not revised when

he/she became incontinent of stools following a change in health status in early spring 2016. [s. 6. (10) (b)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #001 sustained a fracture of a specific limb in early 2016 and was identified as being a two person lift transfer.
In June 2016 the resident was evaluated by the physiotherapist and it was determined the resident was now able to do a pivot transfer and no longer required to be transferred with a lift with assistance of two person unless the resident became weak and pivot transfer is determined to be unsafe.

Inspector #550 reviewed the resident's current written plan of care and observed the following regarding transfers:
Resident must be transferred by ceiling lift with blue sling, assistance of two staff for all transfers. Resident cannot weight bear on right leg.

During an interview, PSW #S104 who cares for resident #001 indicated to the inspector that the resident is now able to do a pivot transfer and that he/she no longer used the lift to transfer the resident since the evaluation with the physiotherapist the week before.
RPN #S106 indicated to the inspector the resident was assessed by physio and is now able to do pivot transfer, the lift is no longer required.

The Director of Care indicated the RN in charge of the unit is responsible for reviewing and updating the resident's plan of care. She further indicated that the changes regarding resident #001's transfers should have been changed by the RN the day the physiotherapist made his assessment.

As evidenced, resident #001's plan of care was not reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #001 developed wounds to a specific body part and in June 2016 the resident was prescribed a specific cream to be applied with specific directions. The resident's daughter indicated to the inspector that she always applies the prescribed cream to resident #001 when she was present but that on June 26, 2016 she was not able to apply it as the cream was locked in the medication cart and the nurse was gone on break with the keys.

The inspector reviewed the resident's health care records and observed that the specific cream was discontinued by the physician on June 22, 2016.

It was documented in the progress notes on June 28, 2016 by RPN #S110 that she had applied the specific cream to the resident. During an interview, RPN #S111 indicated to the inspector that she was not aware that the specific cream for resident #001 had been discontinued and that she had given the cream to the resident's daughter on two other occasions for her to apply to the resident. RPN #106 who is the regular full-time staff on the unit indicated to the inspector that she was not aware that the specific cream for resident #001 had been discontinued and that the tube of cream was still available in the medication cart. She further indicated that if it was discontinued, it should have been removed from the medication cart so staff would not apply it.

As evidenced above, a specific cream was administered to resident #001 on June 28, July 2 and 3, 2016 without a physician's order. [s. 131. (1)]

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.