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
Dec 7, 2016	2016_573581_0001	032968-16	Resident Quality Inspection

Licensee/Titulaire de permis

SHALOM VILLAGE NURSING HOME
60 MACKLIN STREET NORTH HAMILTON ON L8S 3S1

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

SHALOM VILLAGE NURSING HOME
70 MACKLIN STREET NORTH HAMILTON ON L8S 3S1

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

DIANNE BARSEVICH (581), CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 23, 24, 25, 28, 29 and 30, 2016.

During the course of this inspection the following inspections were conducted concurrently:
Critical Incident Inspections:
034136-15 related to resident to resident abuse
000064-16 related to staff to resident abuse
005728-16 related to staff to resident abuse
031491-16 related to resident to resident abuse
During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to policies and procedures, meeting minutes, investigative notes and clinical records.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Executive Coaches of Resident Care (SVO, SVToo), At Home Leaders (RN), Registered Practical Nurses (RPN), Physiotherapist (PT), Life Transition Coach, Registered Dietitian (RD), dietary staff, Personal Support Workers (PSW), residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. After lunch on November 23, 2016, resident #010 was observed in bed with one rotating assist rail in the guard position and one rotating assist rail in the transfer position. Review of the plan of care revealed they required two bed rails in the guard position when in bed for safety as requested by the resident and family. The resident remained in bed with both bed rails in the observed position until the resident was assisted back to their chair, at approximately, 1600 hours. Interview with registered practical nurse (RPN) #102 and registered nurse (RN) #105 confirmed the resident required both rails in the guard position. On November 23, 2016, the plan of care was not provided to the resident as specified in the plan of care, related to bed rail use.

B. The plan of care for resident #012 identified they were cognitively impaired and required consistency of routines for activities of daily living, including cueing and assistance with eating. On November 28, 2016, from 1400 to 1745 hours, resident #102 remained in their room with the door closed. Staff began escorting residents to the dining room at 1700 hours and meal service started at 1735 hours; however, staff did not knock on the resident's door to remind them of dinner service. After 1745 hours, the LTC Homes Inspector inquired as to why resident #012 was not in the dining room. Staff #124 immediately went to get the resident, in which the resident stated that their family

had called to remind them it was dinner time. Observations throughout the course of this inspection and interviews with PSW staff #116 and PSW #117 revealed that the staff usually reminded the resident to come to the dining room before meals and they would come when they wanted to. On November 28, 2016, the staff did not remind the resident to come to the dining room for dinner service until the LTC Homes Inspector inquired about the resident and they were not provided with consistent routine of cueing to come to the dining room for meals. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was not longer necessary

A. Review of resident #080's progress notes identified they were transferred from one home area to another on an identified day in November 2016. Review of the written plan of care indicated that one specific resident was a trigger for their responsive behaviours and staff were to ensure that interventions were in place. Interview with Executive Coach of Resident Care SVO stated that the two resident's no longer lived in the same home area and confirmed the written plan of care was not reviewed and revised when resident #080 changed home areas.

B. Review of the written plan of care for resident #080 revealed they ate at their own table in the dining room due to behaviours. Interview with Executive Coach of Resident Care SVO stated that the resident now sits at a dining room table with other residents since moving to a new home area and confirmed the plan of care was not reviewed and revised related to eating with table mates in the dining room.

C. In 2010, resident #011 was identified as having a device due to a specific diagnosis which required an intervention. Since 2012, consultation notes revealed the resident no longer had the specific diagnosis and interventions were changed to an as needed basis. Electronic treatment administration records (eTAR) were updated; however, review of the written plan of care listed they still required a daily intervention. Interview with RPN #115 confirmed that resident #011 no longer required the daily intervention and the written plan of care was not revised when the care was no longer necessary. (528)

D. The plan of care for resident #017 identified that since June 2016, the resident had ongoing and recurring areas of skin breakdown related to specific diagnoses. Since April 2016, Minimum Data Set (MDS) assessments identified the resident required extensive assistance of two staff with bed mobility. Review of the plan of care did not include

turning and repositioning every two hours as an intervention for staff until October 2016. Interview with Personal Support Worker (PSW) #106 confirmed the resident required assistance with turning and positioning over the past three to four months and registered nurse #105 confirmed that the resident's care plan was not revised to include turning and repositioning every two hours when the resident's care needs changed. (528) [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 that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident was reassessed and the plan of care is reviewed and revised when the resident's care needs changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

Prevailing practices included a document endorsed by Health Canada titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003", created by the Federal Food and Drug Administration, which outlined that decisions to use or to discontinue the use of a bed rail should be made in the context of an individualized patient assessment using an interdisciplinary team with input from the patient and family or the patient's legal guardian. Furthermore, the document detailed guidelines for bed system evaluation and testing for potential zones of entrapment.

A. During the course of the inspection, resident #014 was observed in bed with one rotating assist bed rail in the guard position and the other rotating assist bed rail in the transfer position. Review of the plan of care identified they required one bed rail bed rail raised when in bed to assist with mobility. Interview with RPN #102 and RN #105 confirmed that the resident's assessment for bed rails was for one bed rail only in the guard position and did not include use of the transfer bed rail. It was also confirmed that all residents with an assist rail in the transfer position had not been assessed to require the rail, in accordance with prevailing practices to minimize the risk to the resident.

B. The MDS assessment from a specific month in 2016, identified that resident #014 used other types of side rails less than daily. Observations of the bed system and interviews with RN #105 revealed that the resident did not use bed rails but both bed rails were in the transfer position. Interview with RN #105 confirmed that the home did not consider bed rails in the transfer position as being used and therefore, the resident was not assessed for the use of the rails, in accordance with prevailing practices to minimize the risk to the resident. [s. 15. (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 to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The home's Health and Safety Policy "#111058.00 Nursing-Zero Lift Policy and Protocol" defined a sit to stand lift "to be used for any resident that had been assessed to be a sit to stand lift candidate. All caregivers must use one of the sit to stand lifts and proper sling. Two caregivers must be present during the lifting procedure."

A. On an identified day in November 2016, PSW #117 was observed transferring resident #010 for toileting using a sit to stand lift. No other staff were present during the transfer. Review of the written plan of care identified the resident required the assistance of staff when using the sit to stand lift for toileting related to specific diagnoses. A progress note from November 2016, documented that the resident required a full mechanical lift for all transfers due to a specific condition. Point of care (POC) revealed PSW staff continued to use one staff assistance while using the sit to stand lift. Furthermore, POC documentation from October and November 2016, indicated they used one staff assistance with the sit to stand lift forty percent of the time. Interview with PSW #117 revealed they used one staff for the sit to stand if residents could weight bear. Noting the home's policies and the residents inability to weight bear, PSW #117, did not provide safe transferring techniques to resident #010.

B. On an identified day in November 2016, PSW #107 was observed transferring resident #060 from the toilet to their chair using the sit to stand lift. No other staff were present. The plan of care for resident #060 identified that the resident required extensive assistance with transfers using the sit to stand lift since June 2016, due to an inability to fully weight bear. Review of POC documentation, from October and November 2016, revealed PSW staff documented using one staff assistance to transfer the resident using the sit to stand lift over sixty percent of the time. Interview with PSW #107 confirmed that two staff should have been present when using the sit to stand lift and therefore, did not use a safe transferring techniques when transferring resident #107.

Interview with Executive Coach for Resident Care Area SVToo confirmed that the home directed staff to use two staff for a sit to stand lift on an as needed basis and not as required in the home's Health and Safety Zero Lift Policy and Protocol. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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 failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A. Resident #010 had multiple areas of altered skin integrity related to specific diagnoses. Review of the plan of care identified weekly wound assessments were missing the following:
i. In August 2016, an area of skin breakdown that had previously healed was documented as altered. Weekly wound assessments were not completed for two weeks

in October 2016. The next documented wound assessment in November 2016, noted the wound had increased in size.
ii. In July 2016, an area of altered skin integrity was noted to another area. The weekly wound assessment completed on an identified day in September 2016, noted the wound had worsened. Weekly wound assessments were not completed the following week or for two weeks in October 2016.
iii. In September 2016, a skin tear was noted and weekly assessments were not completed for one week in November 2016.
Interview with RN #105 confirmed that weekly assessments were to be completed in PCC using the weekly wound assessment template and had not been completed for the weeks listed above, although clinically indicated.

B. Resident #014 had multiple areas of altered skin integrity related to specific diagnoses. Review of the plan of care identified weekly wound assessments were not completed as follows:
i. In June 2016, an area of altered skin integrity was noted to a specific area. Weekly wound assessments were not included in the plan of care for the last week of June 2016 and the first week of October 2016. Interview with RN #105 confirmed that weekly assessments were to be completed in PCC using the weekly wound assessment template and had not been completed for the weeks listed above, although clinically indicated.

C. Resident #017 had multiple areas of altered skin integrity related to specific diagnoses. Review of the plan of care identified the following weekly wound assessments were not completed:
i. In June 2016, an area of altered skin integrity was assessed on a specific area and weekly wound assessments were completed until a specific day in August 2016, at which time, the wound remained open. No further wound assessments were completed. Interview with RN #105 confirmed that the wound had since healed but was unsure as to when, due to the incomplete weekly wound assessments.
ii. In October 2016, an area of skin breakdown was noted on a specific location. Weekly wound assessments were not completed since early November 2016. Interview with RN #105 confirmed the wound had not yet healed and weekly wound assessments were not completed as required.
iii. The weekly wound assessments for altered skin integrity on a specific area were not assessed for approximately two weeks in November 2016, as required. Interview with RN #105 confirmed that weekly assessments were to be completed in PCC using the weekly wound assessment template and had not been completed for the weeks listed

above, although clinically indicated. [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 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, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident, who was incontinent and had been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

The plan of care for resident #012 identified they were occasionally incontinent of bladder with a potential for impaired toileting ability related to specific diagnoses, as evidenced by their inability to complete specific activities of daily living. Interventions for staff included but were not limited to, providing supervision and limited assistance when needed and to remind the resident to toilet before and after meals and at bedtime.
i. Observations of the resident on an identified day in November 2016, from 0800 hours to 0900 hours revealed PSW #116 opened the resident's door and reminded them of meal time but did not remind the resident to toilet. After breakfast the resident remained in the dining room until mid morning, at which time, the resident was escorted out of the dining room for a program. The resident was not reminded to toilet before or after breakfast on the identified day in November 2016.
ii. On an identified day in November, 2016, the resident was observed from 1530 to 1745 hours. The resident was not reminded to toilet at any time before dinner service. At 1745 hours, PSW #124 knocked on the resident's door and reminded them it was dinner time, the staff did not remind the resident to use the bathroom before going to the dining room. Interviews with PSW #117 and #116 identified that the resident was forgetful and needed reminding. Interview with RPN #102 confirmed the resident had a specific diagnosis and was occasional incontinence and required reminding from staff for activities of daily living. On two specified days in November 2016, resident #012 did not receive the support from staff related to toileting. [s. 51. (2) (d)]

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 each resident, who is incontinent and has been assessed as being potentially continent or continent some of the time, receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

On November 23, 2016, during an initial tour of the home, the medication stock room on the second floor of SVToo was noted to be unlocked. The door was closed but not locked and no registered staff were present. The LTC Homes Inspector observed a variety of government stocked medications and resident care supplies stored in the room. Volunteers and non registered staff walked past the room during the observation. After approximately two minutes, RN #126 passed by medication room and confirmed the door should have been locked by the RPN when not in use. [s. 130. 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 steps are taken to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A. The home's "Infection Control Specific Disease Protocol #008030.00(e)", directed staff that if residents were infected with a specific diagnosis, signage indicating required precautions would be in place in the PSW flow-sheet binder, medication administration record, on the door, families would be notified and precautions would be discussed at each change of shift, to prevent transmission.

On an identified day in November 2016, resident #010's plan of care was updated to include they had started an intervention related to a specific diagnosis; however, on November 24, 2016, there was no signage noted in the resident's room identifying if additional precautions were necessary for staff and visitors. Furthermore, interview with RPN #102, housekeeping staff #130, and PSW #106, who were all providing care and services to the resident, identified they were all unaware of the resident's specific diagnosis. Interview with RN #105 confirmed that the home's infection protocol was not complied with.

B. The home's policy "Identifications of Residents and Their Belongings: #003120.00" outlined that all residents and their belongings would be easily identified. Directing staff to ensure personal care items were to be placed in a labeled bin. If personal care items were not in the basket, the item was to be labeled.

On the initial tour of the home, the following personal items were noted in spa rooms as follows:
i. the shower room on Oak Knoll home area contained two combs, one used razor, and one used shower cap that were unlabeled
ii. the shower room on Ravenscliff home area contained one comb, one used razor, and two tubs of general use creams that were used; all items were unlabeled. PSW # 108 confirmed that the items should have been labeled for each resident.
iii. The tub room on the Weir home area contained one comb that was unlabeled

Interview with the Executive Coach of Resident Care SVToo confirmed that all personal items were to be labeled in the home. The home's policy related to identification of resident's belongings was not complied with. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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 failed to 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.

On an identified day in October 2016, resident #082 was propelling their wheelchair past resident #080 who was sitting in their wheelchair when they had an altercation. Interview with registered staff #113 and with PSW #101 stated that when the incident occurred that resident #082 was assessed and there was no injury noted. Review of the plan of care identified that the assessment at the time of the incident was not documented. Interview with RPN #113 confirmed they completed the assessment; however, did not document the assessment in the progress notes. Interview with Executive Coach of Resident Care SVO stated the assessment should of been documented in the progress notes. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The home's "Foot Care Protocol #006030.00", directed PSW staff to provide routine foot care to promote and maintain skin integrity and comfort and mobility, including, trimming, cleaning and filing of nails, at the resident's bath time except on those residents diagnosed with a disease process that impaired or compromised a resident's circulation to their feet. Registered staff were to be responsible for diabetic nail care for residents not seen by the foot care nurse.

On an identified day in November 2016, resident #064 received their scheduled shower and nail care was documented as provided. Review of the plan of care identified they were not diabetic and family consented to pay for the foot care nurse, as needed. Interview with PSW #125 who showered the resident, confirmed that finger nail care was provided and the foot care nurse came in, as needed, to provide residents with foot care. Interview with PSW #109, PSW #120, PSW #121, PSW #106, PSW #116 and PSW #117, from both SVO and SVToo home area's revealed that they did not provide residents with basic foot care, stating either "they were not allowed" or "the foot care nurse came in to provide foot care".

Interviews with the Life Transitions Coach, who met with all families on admission, instructed the families that the home was to provide basic foot care to all residents and if they wanted extra services they could consent to the foot care nurse. The Executive Coach of Resident Care Area SVToo also confirmed that the PSWs were to provide basic foot care, including nail care, to all residents on their scheduled bathing days, except for those residents with diabetes. Furthermore, concluded that there had been a miscommunication regarding the requirements of foot care by PSW staff. [s. 35. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to meet the needs of the residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

Review of the MDS assessment in November 2015, identified that resident #084 had normal hearing, was able to make themselves understood and was able to understand others. The admission note indicated there was a communication barrier. Review of the progress notes on an identified day in January 2016, revealed that an incident occurred and the resident was unable to communicate to the PSW staff their needs and they became very angry and upset due to the communication barrier. Review of the written plan of care indicated that altered communication, goals and interventions were not documented until an identified day in January 2016, after this incident occurred. Interview with Executive Coach of Resident Care SVO stated there was a communication barrier and confirmed there were no strategies developed to meet their needs nor any goals and interventions when they were admitted to the home. [s. 43.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, that actions were taken to respond to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A. Review of the MDS assessment in November 2016, for resident #080 indicated they had responsive behaviours. Review of the progress notes from August to November 2016, indicated they refused to take their medication multiple times. Interview with registered staff #119 stated they often refused to take their medication especially when upset and that the staff used specific interventions. Review of the written plan of care did not identify they had responsive behvaviours and interventions and responses to the interventions were not documented and this was confirmed by Executive Coach of Resident Care SVO.

B. Review of the MDS assessment in September 2016, for resident #082 indicated the demonstrated responsive behaviours which were easily altered. Interview with registered staff #112 stated the resident did have responsive behaviours. Review of the written plan of care did not identify the resident demonstrated responsive behaviours and interventions and the resident's responses to interventions were not documented and this was confirmed by Executive Coach of Resident Care SVO.

C. In 2014, resident #012 was admitted to the home, received one scheduled activity of daily living (ADL) and had refused ever since. Interview with the substitute decision maker (SDM) identified that the family was able to convince the resident to participate in part of the activity of daily living on some days but refused most of the time. Interviews with registered staff #102 confirmed the resident had been referred to Behavioural Supports Ontario (BSO) related to responsive behaviours and has been seen by a specialist. PSW #108, PSW #117 and PSW #116, identified that they continued to offer the resident ADL assistance but they still refused and all other non pharmaceutical interventions had been unsuccessful. The document the home referred to as the care plan identified that resident #012 had an impaired ability to independently perform this ADL as evidenced by a specific diagnoses. Interventions directed staff that one person was to provide physical assistance when the resident accepted the ADL task, that the resident preferred this task on two specific days. Interview with registered staff #102 confirmed that the care plan did not document the residents refusal to participate in the ADL for an extended period of time or interventions in place to assist the resident with the task. (528) [s. 53. (4) (c)]

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

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Issued on this 12th day of January, 2017

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

Original report signed by the inspector.