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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 19, 2015	2015_263524_0012	L-002150-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF ELGIN MUNICIPAL HOMES
475 Talbot Street E. AYLMER ON N5H 3A5

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

TERRACE LODGE
475 TALBOT STREET EAST 49462 TALBOT LINE AYLMER ON N5H 3A5

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

INA REYNOLDS (524), CHRISTINE MCCARTHY (588), NANCY JOHNSON (538)

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): April 27, 28, 29, 30, May 1, 4, 5, 6, 2015.

The following Critical Incident inspection was conducted concurrently during this inspection:
Log #004330-15 / CI M583-000005-15. This Critical Incident Inspection is related to a critical incident the home submitted related to the allegations of abuse to a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Seniors Services, the Manager of Resident Care, the Resident Assessment Instrument (RAI) Coordinator, the Resident Care Coordinator, the Maintenance Supervisor, the Registered Dietitian, 3 Registered Nurses, 6 Registered Practical Nurses, 3 Administrative Clerks, 13 Personal Support Workers/Health Care Aides, 1 Dietary Aide, 1 Recreation Assistant, the Resident Council Mayor, the Family Council Chair, 42 Residents and 3 Family Members.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices and, reviewed clinical records and plans of care for identified residents, postings of required information, investigation notes and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care that sets out, the planned care for the resident.

Record review of the Minimum Data Set Assessment (MDS) revealed an identified resident was assessed as requiring extensive assistance and two+ persons physical assist for dressing and personal hygiene care. Record review of the current care plan and Kardex revealed the information from the MDS assessment was not included in the care plan and did not indicate interventions related to dressing and personal hygiene to direct care for the resident.

Staff interview with the Manager of Resident Care confirmed that there was no care plan or Kardex information for the resident related to dressing and personal hygiene and that it is the home's expectation that there should be. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for each resident

that sets out, clear directions to staff and others who provide direct care to the resident.

A) Observations and staff interview with a Personal Support Worker (PSW) revealed an identified resident exhibited responsive behaviours related to cognitive impairment.

Interview with the Personal Support Worker confirmed there are no responsive behaviour interventions in the PSW Kardex to address the resident's responsive behaviours.

B) Record review of the most recent plan of care on PointClickCare revealed an identified resident requires "1 or 2 bedrails elevated when in bed for safety" and is at risk for falls. Record review of the Kardex and the resident's laminated bedside care plan alerts staff that the resident does not require bedrails when in bed.

Interview with a Registered Practical Nurse confirmed the resident does not require bedrails for safety when in bed.

C) Record review of the most recent plan of care and Kardex under the falls and safety focus for a resident revealed the following intervention: "1 bed rail up at night to assist with bed mobility and safety" and "Ensure safe environment i.e. 2 side rails up." This was confirmed by the Manager of Resident Care.

D) Record review of the annual Minimum Data Set assessment for an identified resident revealed that the resident has highly impaired visual function and does not wear glasses. Resident observation on May 4, 2015 hours confirmed the resident was not wearing any glasses.

Record review of the Kardex and Task Flow Sheet on Point of Care for the resident directed staff to apply glasses in the morning and remove in the evening and to document after task completion.

Staff interview with a Personal Support Worker revealed the resident has not worn glasses for some time and the glasses were locked in the resident's closet as requested by family.

Staff interview with the Manager of Resident Care confirmed it is the home's expectation that direction to the Personal Support Workers is provided in the Kardex in Point of Care. The Manager of Resident Care further confirmed that the plan of care and Kardex for the residents were not consistent and did not set out clear direction to staff and others who

provide direct care to the resident. [s. 6. (1) (c)]

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

Record review of the plan of care for an identified resident revealed that the care plan directed staff to check for urinary output once per shift and as needed. Review of the Kardex task record on Point of Care revealed missing documentation of urinary output on twelve out of thirteen days during a specific time frame.

Interview with a Personal Support Worker (PSW) confirmed the missing documentation in Point of Care related to urinary output.

Interview with the Manager of Resident Care and a Registered staff on May 1, 2015 confirmed that the expectation of the home is that documentations are to be completed at the end of each shift as set out in the plan of care. [s. 6. (9) 1.]

4. 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, the resident's care needs change or care set out in the plan is no longer necessary.

Record review of the plan of care for a resident revealed the goal related to Nursing Rehab was that the resident required a walking program. Review of the most recent MDS assessment and staff interview revealed the resident is independent and was no longer on a Nursing Rehab program for walking.

The Manager of Resident Care confirmed that the care plan focus and goal had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

5. Record review of the plan of care for an identified resident revealed that the physicians orders and care plan directed that the resident was to use a specific assistance service chair.

Observations confirmed that the resident was seated in a wheelchair with an assistance device.

Interview with a Personal Support Worker (PSW) and Registered staff confirmed that the resident did not use an assistance service chair because staff were unable to provide the

supportive measures required and the assistance service chair had not been used for approximately one year, as it restricted independent movement.

Interview with the Manager of Resident Care confirmed that the expectation of the home is that the plan of care should be current and updated when the resident's care needs change. [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 there is a written plan of care that sets out, the planned care for the resident, that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, that the provision of the care set out in the plan of care is documented, and, that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with.

Review of the "Edmonton Symptom Assessment Scale – ESAS" policy dated May 2014 revealed: "ESAS-r will be done when there is a significant change in condition".

Observation of a resident revealed the resident cried out in pain on two occasions when a Personal Support Worker attempted to provide care.

Staff interview with two Registered Practical Nurses (RPN) revealed that the resident had recently declined to eat, to drink and take medication for pain. The RPN's further shared that staff did not readminister pain medication to the resident and and did not complete a pain reassessment when the resident demonstrated an increased level in pain.

Interview with the Manager of Resident Care (MRC) confirmed that the home's policy was not complied with and that a pain reassessment should be completed when the resident demonstrated a significant change in condition. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of the "Falls Prevention and Management" policy dated March 2015 revealed: "a fall risk assessment will be completed using the Fall Risk Assessment Tool on all residents" by Registered Nursing staff. "Reassessment occurs whenever there is a change in the resident's health which puts them at increased risk for falling (falls resulting in serious injury)". In addition "Registered staff will: Follow the Managing a Fall: Post Fall Assessment and Management Algorithm - Appendix C. Complete a head to toe assessment."

An identified resident with a prior history of falls sustained an unwitnessed fall resulting in an injury. Record review revealed there is no documented evidence that a fall risk assessment and head to toe assessment was completed by registered staff.

The Manager of Resident Care confirmed the lack of a post-fall risk assessment and head to toe assessment and stated that the home's expectation is that when a resident has fallen, the Falls Prevention and Management policy is complied with. [s. 8. (1)]

3. Review of the "Hydration Assessment and Management" policy dated January 2015 states: "Any residents whose intake is less than 1000 ml per 24 hours is assessed by the RN and plan of care for Encouraging Fluids is initiated by Registered Nursing Staff". "If the issue is not resolved within 72 hours notify the RD in writing; the RD assesses the resident within 7 days of the referral, initiates interventions as appropriate and re-assesses within 7 days".

Record review of the progress notes for an identified resident revealed staff received direction from the physician to "push fluids". The resident was assessed by the home's Dietitian for daily fluid requirements. Record review revealed the resident's daily fluid intake ranged below the daily fluid requirements for a seven day period for each 24-hour period. A review of the progress notes revealed there was no documented evidence that a referral was made to the Dietitian for the resident's low fluid intake over a seven day time span.

Interview with the Manager of Support Services confirmed there was no referral made to the Dietitian related to the resident's low fluid intake. In addition, the Manager of Support Services confirmed the expectation that residents consuming less than their assessed fluid requirement for 72 hours, be referred to the Dietitian to reassess hydration status and initiate interventions. [s. 8. (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 any plan, policy, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily used by residents, staff and visitors at all times.

Observation on a specified date revealed that the call bell in a resident's room was non-functioning at the bedside.

A Personal Support Worker (PSW) confirmed that the bedside call bell was non-functioning and did not activate the call system and called the County Building Maintenance for repair.

Record review of the home's "Call Bell System-Pagers/call bell phones" policy dated March 2015 revealed: "maintain effective call bell monitoring (pager/phones) to ensure equipment on site is functioning correctly" and "Staff will ensure pager/call bell phone is in working order."

Interview with the Maintenance Supervisor and Manager of Resident Care on April 29, 2015 confirmed that the home's expectation is that the home is equipped with a resident-staff communication and response system that can used by residents, staff and visitors at all times. [s. 17. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care is based on, at a minimum, an interdisciplinary assessment of the resident’s health conditions, including pain.

Record review of the clinical record on PointClickCare revealed that an identified resident was ordered pain medication by the physician. Review of the Minimum Data Set assessment revealed that the resident had pain symptoms.

Record review of the plan of care for the resident revealed the absence of goals and interventions related to pain.

Observation of the resident revealed the resident cried out in pain on two occasions when a Personal Support Worker (PSW) attempted to provide care.

Staff interview with the Manager of Resident Care (MRC) confirmed the absence of pain related goals and interventions in the resident’s plan of care. [s. 26. (3) 10.]

2. The licensee has failed to ensure that the plan of care is based on, at a minimum, an interdisciplinary assessment of resident's skin condition, including altered skin integrity.

Record review of the progress notes and skin assessments revealed that treatments were ordered for an identified resident's altered skin integrity. Review of the care plan revealed an absence of strategies and interventions related to the residents skin integrity.

Interview with the Manager of Resident Care and Registered staff on May 4, 2015, confirmed the absence of goals and interventions in the plan of care related to this residents altered skin condition. [s. 26. (3) 15.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on, at a minimum, an interdisciplinary assessment of the resident's health conditions, including pain and an interdisciplinary assessment of the resident's skin condition, including altered skin integrity, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a restraint by a physical device is included in the resident's plan of care.

Observation of an identified resident revealed the resident was seated in a wheelchair with a restraint in place.

Record review of the physician orders for the resident revealed an order for a physical restraint. Review of the hard copy clinical record revealed a restraint consent signed by the Substitute Decision Maker (SDM) for the resident's restraint. The consent was checked off as being updated in the Care Plan by a Registered Staff.

Review of the resident's plan of care revealed the absence of documentation related to the use of the restraint.

Staff interview on April 30, 2015 with the Manager of Resident Care (MRC) confirmed that the care plan did not include a restraint by a physical device. [s. 31. (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 a restraint by a physical device is included in the plan of care, to be implemented voluntarily.

WN #6: 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 has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

Observation during the meal service in the dining room revealed a Personal Support Worker (PSW) touched a resident's hair and then proceeded to assist residents at the table with their meals without proper hand washing. Another Personal Support Worker (PSW) was observed removing dirty dishes from one resident and returned to the table to assist another resident with their meal without proper hand washing. Both Personal Support Workers confirmed that they did not wash their hands or use hand sanitizer.

Interview on April 27, 2015 with the Manager of Support Services confirmed that it is an expectation that staff complete hand hygiene between resident contact or after handling dirty dishes. [s. 229. (4)]

2. Observations during the initial tour of the home on April 27, 2015 revealed multiple used and unlabelled resident personal health care items were found in communal tub rooms.

Interviews with two Personal Support Workers confirmed that the personal care items in the tub rooms were unlabelled and it is the expectation of the home that all resident personal care items are labelled when used in communal rooms.

Interview with the Manager of Nursing Care on April 27, 2015 confirmed that it is the expectation of the home that all residents personal care items and health products are labelled. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 20th day of May, 2015

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

Original report signed by the inspector.