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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Performance Improvement and Compliance Branch

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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
Oct 20, 2015	2015_206115_0023	021704-15	Resident Quality Inspection

Licensee/Titulaire de permis

QCC CORP
3942 West Graham Place LONDON ON N6P 1G3

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

WATFORD QUALITY CARE CENTRE
344 VICTORIA STREET P. O. BOX 400 WATFORD ON N0M 2S0

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

TERRI DALY (115), ALICIA MARLATT (590), ROCHELLE SPICER (516)

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): August 24, 25, 26, 27, 28, 31 & September 1 & 2, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, three Registered Nurses, four Registered Practical Nurses, the Facility Manager, the Maintenance Manager, two Housekeeping Aides, nine Personal Support Worker/Health Care Aides, the Activation Manager, a Minister, one Maintenance Worker, one Dietary Aide, one Physiotherapy Assistant, three family members, and forty one residents.

The Inspector(s) toured all resident home areas, observed dining services, medication storage rooms, medication administration, the provision of resident care, recreational activities, staff/resident interactions, infection and prevention control practices and reviewed resident clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

10 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home furnishings were maintained in a safe condition and in a good state of repair.

During the Initial Tour, Stage 1 Resident Observation and throughout Stage 2 of the Resident Quality Inspection the following was observed:

Rubber molding around the top of tub was coming away from the tub in the Long Hall tub room.

Baseboard was coming away from corner wall outside Resident Room #4 & 6

Large Dining Room
Baseboard heater cover was falling off.

TV lounge (across from nursing station)
The half divider wall was missing pieces of wood trim along bottom base of wall.

Small Dining Room
Baseboard was coming away from corner wall.
Cupboards were chipped and laminate was missing along the edge and lifting along bottom of cupboards.

Resident Rooms
Room #13 door was heavily scraped, scuffed and paint chips along bottom, bathroom counter top laminate was lifting/separating.
Room #28 tiles on right side of toilet were separating and pulling away from floor.
Room #11 resident bathroom caulking around sink and toilet cracked and worn.
Room #20 bathroom floor tiles separated along far wall and significantly damaged behind toilet. The underfloor was visible, and appeared wet with debris build up.
Room #18 one bathroom wall was only half painted and had scrapes. Floor tiles by toilet were bubbled up and uneven.
Room #12 door frame had paint chips and scrapes, masking tape noted along window frame.

Interviews with the Administrator and Maintenance Manager on September 2, 2015, confirmed the expectation that the home was maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home furnishings are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and is therefore subject to lighting requirements under the section of the lighting table titled "All Other Homes".

During Stage 1 Resident Interview a resident stated "the lighting is not great, it can be hard on the eyes".

A) On August 28 & 31, 2015, lighting levels were measured in common spaces, dining areas, resident bedrooms, resident bathrooms and corridors.
All light fixtures were turned on if not already illuminated and allowed to warm up.
The homes Facilities Manager was on site and using a hand held light/lux meter, held approximately three feet above and parallel to the floor, the following measurements were acquired:

The Long Hall corridor from Resident Room #10-16 was observed to be dimly lit.
Immediately outside of Room #16 in the Long Hall measured 121 lux
Immediately outside of Room #12 in the Long Hall measured 140 lux

Corridor lighting levels must be a continuous minimum level of 215.28 lux.

The Facility Manager confirmed that the appropriate bulbs were not being utilized in the hall way ceiling fixtures. Fixtures equipped with the LED type bulbs met or exceeded the lighting regulations.

B) Resident rooms were equipped with a small over bed light with an upper and lower bulb. Measurements were taken in Room #12 which is representative of resident rooms.

On August 28, 2015 measurements were taken approximately three feet above and parallel to the floor by the resident bed.

Bed A measured 180 lux
Bed B measured 153 lux
Bed D measured 154 lux

The minimum required level is 215.28 lux for areas in and around the bed, walking paths and areas of general activity.

Maintenance replaced bulbs in the upper and lower portion of the over bed fixtures with newer mini spiral 23 W light bulbs 1600 lumens in Room #12.

Bed A measured 220 lux
Bed B measured 251 lux
Bed D measured 262 lux

A resident remarked to an Inspector how much brighter the lighting was in the room and how much easier it was to see after the bulbs were changed.

The Facility Manager acknowledged that the resident rooms and part of the Long Hallway were not adequately lit.
The Administrator confirmed that light bulbs for the resident rooms had been ordered and would be replaced the week of September 1, 2015, and that the home was deciding whether bulb replacement or fixture replacement in halls ways would be more beneficial. [s. 18.]

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 lighting requirements are maintained, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the homes written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A review of a resident's progress notes and an interview with a Registered Staff Member revealed that an incident had occurred between two residents. This incident was witnessed by two staff members.

A) The policy and procedure Prevention, Elimination and Reporting of Abuse, effective date July 2014, review date May 2015 was reviewed.

The Administrator confirmed the licensee's policy and procedure titled; "Prevention, Elimination and Reporting of Abuse"; effective date July 2014, review date May 2015, included specific behaviours under the definition of physical abuse and included protocols for reporting allegations of resident abuse and for investigating allegations of resident abuse by a resident.

B) The inspector was unable to locate any documentation in the resident's health care record in relation to an assessment of this resident after the incident occurred. An interview with the Registered Staff Member who witnessed the incident confirmed that the resident was assessed after the incident but the assessment was not documented in the health care record.

The Administrator confirmed the following procedures listed in the licensee's protocols for reporting and investigating alleged abuse were not completed in relation to the incident.

The staff member receiving the initial report of abuse had not initiated the Licensee's "Investigation of Allegations of Abuse Form".

Information obtained during the investigation after the incident was not documented in writing or tape recorded.

The staff member receiving the initial report did not ensure that all information was documented in both resident's charts in chronological order. The Administrator confirmed the incident was documented in one resident's chart but not in the other resident's chart. [s. 20. (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 the homes written policy that promotes zero tolerance of abuse and neglect of residents is complied with, 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure the responsive behaviour plan of care was based on an interdisciplinary assessment of a resident that included any mood and behaviour patterns, including wandering and any identified responsive behaviours.

A review of a resident's progress notes, revealed a "responsive behavior physical - resident to resident note" that was documented. The progress note indicated a staff member had witnessed the incident.

An interview with the Administrator was conducted related to the resident's plan of care for Responsive Behaviours. The inspector was not able to locate any information in the resident's plan of care in regard to an incident involving another resident or behaviours specific to that resident.
The Administrator confirmed the resident's plan of care did not identify behaviours specific to this resident The Administrator also confirmed the expectation that the resident's health care record in Point Click Care under both the Care Plan and Kardex sections should have been updated to reflect a recent incident [s. 26. (3) 5.]

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 behaviour plans of care are based on interdisciplinary assessments, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The Licensee has failed to ensure that required information was posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulations specifically, the required information for the purposes of subsections 79. (1) and (2)of the Long Term Care Homes Act, 2007:

(d) an explanation of the duty under section 24 to make mandatory reports.

On August 24, 2015, Inspectors completed the initial tour of the home as part of the Resident Quality Inspection.

The inspectors were unable to locate any posting of an explanation of the duty under section 24 to make mandatory reports.

The Director of Nursing confirmed with an Inspector that the Public Information Binder posted in the front entrance also did not contain a copy of a person's duty to make mandatory reports to the Director.

On September 1, 2015, the Inspector was unable to locate an explanation of the duty under section 24 to make mandatory reports in a conspicuous location.

Staff members were interviewed to determine where an explanation of the duty under section 24 to make mandatory reports was posted within the long term care home. Three staff were unable to locate the mandatory posting of an explanation of the duty under section 24 to make mandatory reports within the long term care home. [s. 79. (3) (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 required information is posted in a conspicuous and easily accessible location, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that housekeeping procedures are implemented for cleaning of the home.

A review of the homes policy and procedure Housekeeping Duties -Saturday to Thursday Effective Date: January 13, 2014

The procedure indicates:
Clean rooms thoroughly as follows
-wipe off baseboards wipe down cob webs
-Dust mop the floor with clean or treated mop.
-Clean washroom the wet mop floors.
-Then polish floors.

During the initial tour, stage 1 Resident Observation and Stage 2 of the RQI the following was identified:

Main Dining Room
Cob webs, dust and debris noted in window sills.
Black wax build up with dust and debris noted around the perimeter of the dining room along the green coloured wall.

Front Lounge, Front Activity Area and the lounge at the end of Long Hall
Cob webs, dust, debris dead bugs and spiders in window sill.

Seven Resident Rooms/Bathrooms
Cob webs, dust, debris and spiders noted in the corners of the bathrooms and or behind the resident room doors.

Observed plastic glove on floor in the front entrance way Monday, August 24, 2015. The glove was observed again on Tuesday, May 25, 2015 at 4 PM.

Long Hall
The hallway along the baseboard and floor has areas of black wax build up and dust.

Two housekeeping staff and the Administrator indicated that it is the expectation that cleaning of resident rooms on a weekly basis, including behind doors, flooring, and hallways be completed to maintain cleanliness per the home's procedures. [s. 87. (2) (a)]

2. The licensee failed to ensure that the home's procedures for addressing incidents of lingering offensive odours was implemented.

Lingering offensive urine odours were identified during Stage 1 on August 25, 2015, in two resident room bathrooms.

On August 26, 2015 and August 28, 2015 the urine odour continued to exist in both of these resident bathrooms.

A walk through of these bathrooms was conducted with the housekeeping aide on August 26, 2015. Staff acknowledged the offensive odours and provided a detailed step by step process the home utilizes in an attempt to eliminate these odours using a chemical called Clax Enzyme 2 Treatment. The aide was going to implement the chemical treatment in each of these rooms on August 27, 2015.

On August 28, 2015 the lingering offensive urine odour remained present in both bathrooms when checked several times throughout the day.

A review of the home's Offensive Odours Policy dated December 30, 2013, indicated the use of charcoal or an Ozone machine for offensive odours.

Neither of these resident washrooms had evidence of charcoal usage or an Ozone machine as per the policy.

The Administrator confirmed that the odours continued to exist and that the policy and procedure in place was not implemented by staff. [s. 87. (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 housekeeping procedures are implemented for cleaning of the home, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's Substitute Decision Maker (SDM) was notified within 12 hours upon becoming aware of a witnessed incident between two residents.

On an identified date, there was an incident between two residents.

The inspector was unable to locate any documentation in the two resident's health care records to confirm that the resident's SDMs had been notified of an incident.

The Administrator confirmed the Administrator, Director of Nursing and/or delegate did not notify the resident's SDM(s) about the identified incident. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's substitute decision-maker is notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM), if any, and any person that either of them may direct were given an opportunity to participate fully in the annual care conference.

During Stage 1 Family Interview of the Resident Quality Inspection,a resident's SDM was asked:
Are you invited to participate in a six-week and annual care planning conferences?
The SDM responded "I don't recall being invited but maybe its something I wouldn't have been able to attend."

A record review revealed that the resident had an annual care conference in 2015.
The electronic care conference record under the Minimum Data Set Assessment(MDS) did not indicate that the SDM was in attendance.
The home's Director of Nursing reviewed the process in place for booking and sending out invitations to the annual care conferences, and revealed that the family member/SDM identified should have been invited.
During a record review the home was unable to provide proof that the letter of invitation that is typically retained on the resident's record existed.

The Director of Nursing confirmed that it was the home's expectation that the first listed SDM be invited to the initial admission six week care conference and annual thereafter. [s. 27. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a

minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A) A review of the Resident's Council meeting minutes revealed several discussions and on going concerns related to residents missing baths due to staffing shortages.
Minutes from September 28, 2014 indicated the following concern:
"Residents expressed a concern about not getting their baths because the bath girl phones in and cancels her shift."

Minutes from October 28, 2014 indicated the following concern:
"Discussion of residents not getting baths. Council discussed inviting Administrator or the Nurse Manager to the next meeting."

Minutes from November 25, 2014 indicated the following:
"The Nurse Manager attended the meeting to provide feedback about the home's plan to address missed baths."

B) A review of the clinical records for a resident revealed progress note documentation indicating "No bath aide this am".

An interview with a Registered Nurse indicated that this documentation would mean that the bath was not provided due to staff shortage.

A review of the resident's plan of care revealed the resident was to receive two baths per week.

A review of the Point of Care(POC) record revealed that staff had not signed that a bath was completed.

A review of the POC PRN bath documentation revealed that a make up bath was not provided on an alternate day.

C)During Stage 1 Resident Interview, a resident expressed to an Inspector "I have missed baths sometimes" and made reference to a specific day.

A review of the resident's clinical record in Point of Care revealed that staff had not signed that a bath was completed as per the resident's regular assigned bath day.

The Registered Nurse reviewed the POC records and indicated that if the bath was made up on an alternate day staff would complete in POC under PRN bath, she was unable to determine that this occurred.

The home did not have a policy to address missed baths but the DOC confirmed that a procedure was in place for staff to attempt to make up baths when missed or working short.

The DOC confirmed the expectation that residents were bathed at a minimum twice per week per their individualized plan of care. [s. 33. (1)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistive Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if:

The use of a PASD has been consented to by the resident or, if the resident was incapable, a Substitute Decision Maker (SDM) of the resident with authority to give that consent.

A review of a resident's health care record, observations and interviews with the resident, the Director of Nursing, one Personal Support Worker and one Registered Nurse revealed that the resident has used a PASD.

The Director of Nursing confirmed the resident had a SDM and had requested the home obtain the consent from the SDM for the use of the PASD. A review of other consent forms for this resident and an interview with a Registered Nurse confirmed the resident's SDM had signed all other consents to date except for consent for the use of the PASD.

The Director of Nursing and one Registered Nurse confirmed the use of the PASD for the resident had not been consented to by the resident or the resident's SDM who had authority to give that consent to date. [s. 33. (4) 4.]

Issued on this 22nd day of October, 2015

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

Original report signed by the inspector.