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

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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 14, 2015	2015_343585_0021	030631-15	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

WENTWORTH LODGE
41 SOUTH STREET WEST DUNDAS ON L9H 4C4

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

LEAH CURLE (585), CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581)

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 12, 13, 16, 17, 18, 19, 20 and 23, 2015

This inspection was conducted concurrent with an inquiry, log #019839-15, related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with residents, families, registered nursing staff, personal support workers (PSWs), dietary staff, maintenance staff, the registered dietitian (RD), physiotherapists, physiotherapy assistant, the Resident Assessment Instrument (RAI) coordinator, infection control practitioner, director of food services, director of building services, nurse managers, the director of nursing and the senior administrator.

The inspectors also toured the home, observed the provision of care and services and reviewed documents including but not limited to: clinical health records, policies and procedures, menus, production sheets, staffing schedules, meeting minutes, training records, program evaluations records and logs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

12 WN(s)
9 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 there was a written plan of care for each resident that set out the planned care for the resident.

A) On an unspecified date in November 2015, registered staff #100 was observed crushing medications before administering them to resident #020. Review of resident #020's written plan of care identified they were a potential risk for aspiration related to

swallowing difficulty but did not direct staff to crush medications. Interview with registered staff #100 confirmed the resident required their medications to be crushed; however, was not included on the written plan of care.

B) On unspecified dates in November 2015, loud music was playing in the home. Registered staff #100 indicated it was the responsibility of staff to ensure the volume remained at an acceptable level. Interview with personal support worker (PSW) #102 confirmed that they were unaware of any limitations to volume levels. The director of nursing (DON) confirmed that there was no written plan to direct staff how to ensure that volume levels were kept at an acceptable level.

C) Resident #023's plan of care directed staff to feed the resident slowly using teaspoons only. On an unspecified date in November 2015, PSW #126 was observed providing fluids to the resident during a meal, using an adaptive drinking cup. The resident was noted coughing twice after each sip. PSW #126 reported that they first used a teaspoon to provide the drink but did not during the entire meal, instead using the adaptive cup for the second drink. Interview with the registered dietitian (RD) confirmed the resident could use adaptive cup for fluids; however, it was not included in their written plan of care.

D) Review of resident #004's quarterly Minimum Data Set (MDS) assessment completed in August 2015 indicated they were bedfast. Review of three previous quarterly assessments also coded the resident as bedfast. Registered staff #107 and #112 reported that the resident chose to be in bed all day and night and only got up for one or two meals for approximately 20 minutes. Review of the written plan of care did not indicate the resident's preference and planned care to be in bed all day and this was confirmed by registered staff #107. [s. 6. (1) (a)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A) In April 2015, the MDS assessment for resident #011 under Section E, "Mood and Behaviour Patterns", indicated they resisted care daily during the seven day review period. In July 2015, their MDS assessment indicated they did not demonstrate resistance to care during the review period, and exhibited no change in their mood status compared to the April assessment. In October 2015, their MDS assessment indicated they exhibited resistance to care daily, and their mood status had not changed compared

to the July assessment. Review of the Point of Care (POC) documentation completed by PSWs during the July assessment review date (ARD) period revealed the resident exhibited resistance to care daily. PSW #106 and registered staff #113 both reported the resident was resistive to care daily during the July period. Registered staff #113 confirmed the MDS assessment from July 2015 was not consistent with the PSWs assessment of the resident's behaviour during the July review period.

B) In September 2015, the MDS assessment for resident #002 under Section E, "Mood and Behaviour Patterns", indicated they exhibited physically abusive behaviours during the seven day review period. Review of POC documentation completed by PSWs during the September ARD period revealed the resident did not demonstrate any physically abusive behaviours. Registered staff #113 confirmed the resident exhibited physically abusive behaviours in August 2015, but not during the ARD period, and the MDS assessment from September 2015 was not consistent with the PSWs assessment of the resident's behaviour during the review period.

C) In June 2015, the MDS assessment for resident #005 under Section H, "Continence in the last 14 days", identified that they went from incontinent all or most of the time to frequently incontinent of bladder; however, did not identify there was an improvement. Review of the POC documentation completed by PSWs during June ARD period revealed the resident was incontinent all or most of the time, with only two documented episodes of some control present. Interview with the registered staff #108 confirmed that the MDS assessment coding from June 2015 was not consistent with the PSWs assessment of the resident's continence in POC during the ARD period.

D) In October 2015, the MDS assessment for resident #010 under Section G, "Physical Functioning and Structural Problems", indicated they were totally dependent with two person physical assist for both transfers and bed mobility. Review of the POC documentation completed by PSWs during the October ARD period indicated the resident required extensive assistance with two staff for eleven times for transferring and fifteen times for bed mobility. Review of the resident's written plan of care and interview with PSW #101 revealed the resident was transferred using a sit and stand lift and was able to assist with bed mobility. Interview with registered staff #108 confirmed the resident was extensive assistance with two staff for transferring and bed mobility and the MDS assessment coding from October 2015 was not consistent with the PSWs assessment of the resident's transferring and bed mobility in POC during the ARD period.

E) In August 2015, the MDS assessment for resident #013 under Section I, "Disease Diagnosis", identified the resident as having an infection. During the August ARD period, the physician assessed the resident and in a progress note documented that they did not have an infection. Interview with registered staff #108 confirmed that the MDS assessment from August 2015 was not consistent with the physician assessment during the ARD period.

F) In September 2015, the MDS assessment for resident #006 under Section G, "Physical Functioning and Structural Problems" indicated they were bedfast all or most of the time. Review of the resident's written plan of care revealed they were to be straight up in their wheelchair during meals and snacks and for twenty minutes post meals. During the course of this inspection, the resident was observed positioned in their wheelchair sitting upright for over two hours. PSW #101 and #123 both reported the resident was positioned upright for their meals and snacks and confirmed they were sitting upright for over four hours during day and evening shifts. Interview with registered staff #100 confirmed that the resident was not bedfast all or most of the time and that their assessments were not consistent or complemented each other.

G) On two unspecified dates in November 2015, resident #004 was observed in bed with two quarter bed rails raised. Review of the Bed Risk Assessment Risk completed for resident #004 as well as their written plan of care indicated they required the bed rails raised for bed mobility and positioning as a personal assistance service device (PASD). PSW #109 stated in an interview that the resident used the raised bed rails for transfers and bed mobility. Review of the MDS assessment in August 2015, indicated that bed rails were not used. Interview with registered staff #108 confirmed that the resident used bed rails daily for turning and positioning and that the assessments were not consistent with or complemented each other.

H) In May 2015, the MDS assessment for resident #004 under Section H, "Continence in the last 14 days" indicated they were frequently incontinent of bladder. In August 2015, the MDS assessment indicated they were incontinent of bladder and coded as having no change in their urinary continence. The Resident Assessment Protocol (RAP) completed during the same review period stated the resident was frequently incontinent of bladder. Interview with the Resident Assessment Instrument (RAI) coordinator confirmed there was a change in their urinary continence between quarterly MDS assessments and that the assessments were not consistent with or complemented each other.

I) In September 2015, a RAP completed for resident #002 indicated they exhibited

behaviours during the seven day review period. Review of flow sheets completed by PSWs as well as progress notes indicated the resident did not demonstrate any behaviours between the September review period. Interview with registered staff #113 confirmed the resident did not demonstrate the behaviours during the September 2015 period and the MDS assessment was not consistent with other assessments in the resident's clinical record. [s. 6. (4)(a)]

3. 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) Resident #002 was assessed at high nutritional risk related to low food intake and was at risk of dehydration related to not consuming their target fluid requirements, as confirmed by the RD. Their plan of care stated they were to receive an adaptive eating device to promote independence with eating and to provide 125 millilitres (mL) water at medication pass three times a day to promote hydration, as documented in a RD assessment note from September 2015.

i) On two unspecified dates in November 2015, during meal time observations, resident #002 did not receive their adaptive eating device, as confirmed by dietary staff #115 and #117.

ii) On an unspecified date in November 2015, during the 0800 and 1200 hour medication pass, resident #002 did not receive 125 mL of water. Review of the resident's medication administration records from November 2015 did not include the water. Registered staff #113 reported they were unaware the resident was to receive the water and that it did not populate in the resident's electronic medication administration record (eMAR); however, confirmed the plan of care stated they were to receive water during medication pass.

B) Resident #011's plan of care indicated they were at high nutritional risk, as confirmed by the RD. The resident's plan of care stated they were to receive a fortified nutrition protocol as well as 125 mL of water with each medication pass to increase fluid intake.

i) During a lunch observation on an unspecified date in November 2015, resident #011 did not receive their fortified nutrition protocol as outlined in their plan of care, which was confirmed by dietary staff #115.

ii) During a breakfast observation on an unspecified date in November 2015, the resident did not receive their fortified nutrition protocol as instructed their plan of care, as

confirmed by dietary staff #117. Interview with the RD confirmed the resident was to receive the fortified protocol as indicated in their plan of care.

iii) On an unspecified date in November 2015, during an observation of breakfast and the 0800 hour medication pass, resident #011 consumed three cups of fluid provided by the dietary staff. Review of POC documentation completed by PSWs noted resident #011 consumed three cups of fluid. Review of the resident's eMAR also noted they received 125 mL of water at the 0800 hour medication pass. Interview with registered nursing staff #113 reported nursing did not provide additional fluid to residents with orders supplemental water in their eMAR, and instead served as documentation to verify the resident consumed water provided by dietary staff. Interview with the RD reported nursing staff were to provide additional fluids as per the orders in the eMAR and the care set out in the resident's plan of care was not provided as specified in the plan. [s. 6. (7)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary.

A) Resident #012's written plan of care identified they required compression stockings daily. A Medication Review form dated November 2015 noted that the compression stockings had been on hold for several months. Interview with registered staff #103 confirmed that the stockings were on hold; however, the written plan of care was not updated to include the change.

B) Resident #010's written plan of care indicated they were being positioned in a Broda wheelchair which was to be tilted between meals. During the course of the inspection, the resident was observed sitting in a regular and tilted wheelchair. Interview with registered staff #100 confirmed the resident was no longer sitting in a Broda wheelchair and their plan of care was not updated when the care set out in the plan was no longer necessary.

C) Resident #004's written plan of care and kardex indicated they were to be supervised for transfers from bed to wheelchair and staff provided cueing and encouragement. PSW #109 stated the resident was a one person extensive assistance transfer from bed to wheelchair. Registered staff #107 confirmed the resident was a one person extensive assistance transfer and the resident's written plan of care was not updated when their care needs changed.

D) Resident #004's written plan of care and kardex indicated they were toileted and wore a brief or pull-up continence product. PSW #109 stated the resident preferred to be changed in bed and only wore a brief. Interview with registered staff #107 and #108 confirmed the resident was no longer toileted, was changed in bed with a brief, no longer wore a pull up product and the plan of care was not updated when their care needs changed.

E) Resident #004's written plan of care indicated that registered staff were to administer antibiotics and monitor for effectiveness. Review of the resident's progress notes revealed they were on antibiotics in September 2015 for treatment of an infection and received their last dose in September 2015. Interview with registered staff #105 stated the resident was no longer on antibiotics and confirmed that the care plan was not revised when care set out in the plan was no longer necessary. [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 and ensuring that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and the care set out in the plan of care is provided to the resident as specified in the plan,, to be implemented voluntarily.

WN #2: 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 failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

i) On November 12 and 20, 2015, the meeting room and training room on the second floor were observed accessible to residents, with no resident-staff communication and response system present. Interview with the DON confirmed the areas were accessible and used by residents, and did not contain resident-staff communication and response systems.

ii) On November 20, 2015, the outdoor balcony adjacent to the dining room in the rose court home area was observed accessible to residents, with no resident-staff communication and response system present. The director of building services reported residents used the outdoor area and confirmed it did not contain a resident-staff communication and response system. [s. 17. (1) (e)]

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 and ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents,, to be implemented voluntarily.

WN #3: 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 failed to ensure that the use of the PASD was consented to by the resident or, if the resident was incapable, a substitute decision maker (SDM) of the resident with authority to give consent.

A) On two unspecified dates in November 2015, resident #004 was observed in bed with two bed rails raised. Review of the resident's Bed Rail Risk Assessment and the written plan of care indicated they required two quarter bed rails raised when in bed for transferring and bed mobility as a PASD. Interview with registered staff #124 and #125 confirmed there was no consent documented for the use of the bed rails as a PASD.

B) During the course of the inspection, resident #010's bed was observed with two quarter assist rails raised. Review of the resident's Bed Rail Risk Assessment and the written plan of care indicated they required two quarter bed rails raised when in bed for repositioning as a PASD. Registered staff #100 confirmed the resident used the bed rails; however, there was no consent documented for the use of bed rails as a PASD. [s. 33. (4) 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 and ensuring that 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 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,, 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

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 that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

A) In an unspecified month in 2015, resident #012 returned to the home after a stay in the hospital. Their plan of care identified that they were at risk for altered skin integrity and had a history of skin breakdown. At the time of readmission, the registered staff documented assessments on some but not all areas of the resident's skin. Four days later, PSW staff documented that the resident had skin discolouration and registered staff documented redness to areas not included in the initial assessment. Interview with registered staff #105 confirmed that a head to toe skin assessment was not completed upon resident #012's return from hospital. [s. 50. (2) (a) (ii)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) In May 2015, resident #001 was noted to have a new area of altered skin integrity, the physician was made aware, and new treatment orders were received. In June 2015, the treatment was documented as being ineffective and the physician suggested the alteration was pressure related with new interventions suggested. Registered staff documentation referred to the wound from June to September 2015 but did not include a weekly assessment of the wound. Interview with registered staff #105 confirmed wound assessments were not completed weekly from May to October 2015 for resident #001.

B) In June 2015, resident #012 developed multiple areas of altered skin integrity, an assessment of each wound was completed at that time. An additional area of skin breakdown was documented by registered staff in September 2015. Review of the plan of care included one wound assessment of each identified area of altered skin integrity in June 2015, one in September 2015 and one in November 2015. Interview with registered staff #105 confirmed that wound assessments were not completed weekly for resident #012. [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 and ensure that 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,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with a range of continence care products that promoted continued independence wherever possible.

During the course of the inspection, it was identified that the home did not include a pull up type product in the range of continence care products provided to residents.

i) Resident #042's plan of care identified they were toileted without assistance and wore a pull up product. Interview with the resident's SDM stated that they were informed that the home did not provide a pull up type product; therefore, the family was paying for a pull up to try and maintain the resident's independence with toileting. Interview with PSW staff stated the resident wore a pull up product as they were able to toilet themselves independently and that the product was supplied by the resident's family.

ii) Resident #044's plan of care identified they were on an incontinence program and wore a pull up type product. Interview with direct care staff confirmed that the resident wore a pull up product provided by the family and they were able to self toilet successfully with the use of a pull up type product. Interview with resident #044's family confirmed that they were instructed that the home did not provide a pull up type product, therefore, they had been paying for a pull up type product to try and maintain the resident's independence with toileting.

iii) Resident #046's plan of care identified that they were on an incontinence program and wore a pull up product. Interview with the registered staff #114 stated they no longer wore a pull up as the home did not provide them and the resident did not want to purchase them as they felt they were too expensive. Interview with resident #046's family confirmed that the resident's preference was to wear a pull up but were told on admission that the home did not provide pull up products, however the resident did not want to pay for their own pull ups so did not wear any product. Interview with resident #046 who confirmed they would like to wear a pull up if they did not have to pay for them as they cost too much money to purchase on their own.

Interviews with the TENA representative and registered staff #105 confirmed that home's range of continent care products did not include a pull up type product; therefore, resident or family member were required to pay for a pull up type product on their own. The home did not provide continent care products that promoted resident #042, #044 and #46's comfort, ease of use, and independence. [s. 51. (2) (h) (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 and ensure that residents are provided with a range of continence care products that promote continued independence wherever possible,, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

A) Resident #65's plan of care stated they were at high nutritional risk related to swallowing issues, as confirmed by RD. On an unspecified date in November 2015 during a meal, resident #065 was observed receiving total assistance with eating, with their neck appearing hyper extended and torso reclined in tilted wheel chair. PSW #131 reported the resident appeared slanted in their chair during the meal and they noticed the positioning earlier in the day as well as the day prior. Registered staff #132 confirmed resident was tilted back in an unsafe position for feeding. (585)

B) Resident #060's plan of care stated they were at high nutritional risk with potential risk

of choking and that they were to maintain an upright position for eating and drinking and for 45 minutes post eating/drinking, as confirmed by the RD.

i) On an unspecified date in November 2015 during a meal, resident #060 was observed receiving total assistance with eating, reclined in a tilted chair with their head and torso reclined, and presented a wet cough. Approximately 30 minutes post meal, the resident was observed reclined 45 degrees.

ii) On an unspecified date in November 2015, approximately 15 minutes after a meal, resident #060 was observed reclined 30 degrees in a tilted chair. PSW #106 reported the resident was regularly reclined after meals. Interview with registered staff #107 confirmed the resident was to be fed upright and maintain an upright position for 45 minutes post meal to prevent aspiration.

C) Resident #063's plan of care stated they were at high nutritional risk, as evidenced by chewing and swallowing difficulties, as confirmed by the RD. On an unspecified date in November 2015 during a meal, the resident was observed receiving total assistance with eating, in a reclined position while eating, with their neck hyper extended, coughing and appearing distressed. Registered staff #114 reported the resident needed to be monitored and readjusted during the meal to maintain an upright position.

D) Resident #064 was identified at high nutritional risk related to their decline in ability to self feed and potential for risk of choking, as confirmed by the RD. On an unspecified date in November 2015 during a meal, the resident appeared slouched in a tilted chair with their neck hyper extended and torso reclined while receiving assistance from staff with eating. PSW #118 confirmed the resident was tilted and needed to be tilted up to achieve a safer feeding position. The RD confirmed the resident should be seated upright to prevent aspiration. [s. 73. (1) 10.]

2. The licensee failed to ensure that no person simultaneously assisted more than two residents who needed total assistance with eating or drinking.

On an unspecified date in November 2015 during a meal service, PSW #109 was observed providing total assistance with eating to resident #011, #060 and #061. PSW #109 stated the three residents required total assistance and that they were assisting them simultaneously. The director of food services confirmed the identified residents all required total assistance with eating, and staff were to assist a maximum of two residents at the same time who required total assistance with eating or drinking. [s. 73. (2) (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 and ensuring that the home has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: that staff applied the physical device in accordance with any manufacturer's instructions.

On an unspecified date in November 2015, resident #062 was observed sitting in a wheel chair with a lap belt applied. The belt was applied approximately four finger widths from their torso. PSW #122 reported the resident used the belt to prevent falls and could not release the belt on their own. Registered staff #121 confirmed the resident used the belt as a restraint to prevent falls and the belt was was too loose and not applied in accordance to manufacturer's instructions. [s. 110. (1) 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 and ensuring that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, staff apply the physical device in accordance with any manufacturer's instructions,, to be implemented voluntarily.

WN #8: 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 all areas where drugs were stored were kept locked at all times, when not in use.

On November 17, 2015, at 1215 hours, an unlocked medication cart was sitting outside the rose court dining room. All residents were eating lunch in the dining room and registered staff was not visible. Approximately five minutes later, registered staff #100 returned to the medication cart. Interview with registered staff confirmed the cart was left unlocked and unattended while they toileted a resident. [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 and ensuring that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use,, to be implemented voluntarily.

WN #9: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

As part of the home's infection prevention and control program, their policy, "Labelling residents' personal items, policy no: IC-02-07", reviewed May 27, 2015, stated to prevent or minimize the spread of infection, all residents' personal toiletry items are to be labelled with resident names at all times.

On November 12, 2015 at approximately 1230 hours, unlabelled personal items were observed in following tub and shower rooms:

i) Three used deodorants a counter in the maple lane tub room;

ii) One nail clipper on a counter in the oak lane tub room;
iii) One hair brush in the oak lane shower room; and
iv) One nail clipper and zinc oxide cream on a counter in trillium court tub room.

In the afternoon of November 12, 2015 unlabelled, used personal items were observed in following resident shared washrooms:

i) Two toothbrushes, one comb, one deodorant and vaseline in a trillium court washroom

ii) One nail clipper in a maple lane washroom; and
iii) One trimmer, one deodorant and one toothbrush in a trillium court washroom

The DON confirmed resident personal items were to be labelled and the home did not comply with their expectation to label personal items to prevent or minimize the spread of infection. [s. 229.
(4)]

2. The licensee failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if none, in accordance with prevailing practices.

Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Surveillance of Health Care-Associated Infections In Patient and Resident Populations, Third Edition, dated July 2014, recommends Long Term Care Homes have a surveillance System to monitor and analyze infections, including but not limited to, the documentation of new symptoms of infection every shift.

In August 2015, resident #004 began displaying symptoms of possible infection. The day after they became symptomatic, the resident was diagnosed with an infection and was given antibiotics. Review of clinical documentation revealed that staff were not consistently monitoring and documenting symptoms of infection on every shift. Interview with registered staff #105 confirmed that staff were not documenting resident #004's symptoms every shift. [s. 229. (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 and ensuring that all staff participate in the implementation of the program,, to be implemented voluntarily.

WN #10: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy "Fall Management Program, Policy No: NM 03-02-08", last revised October 14, 2014, directed registered staff to complete a head injury routine (HIR) for all unwitnessed falls and the resident would be monitored every hour for the first four hours and then every four hours for twenty-four hours post fall for signs of neurological changes, and directed registered staff to document using a follow up note to the fall note in Point Click Care (PCC) each shift for a minimum of twenty four hours post fall.

i) On two unspecified dates in November 2015, resident #007 fell and both falls were documented as unwitnessed. Review of resident's clinical record indicated that for the first fall, a HIR was not completed every four hours post fall and for the second fall, a HIR was not initiated post fall. Interview with registered staff #114 confirmed that the HIR was not completed for both falls according to the home's policy.

ii) In September 2015, resident #010 fell, with no injury noted. Review of the resident's progress notes revealed that only one post fall note was completed after the fall. Interview with registered staff #100 confirmed that a post falls note was not completed on every shift and the home's policy was not complied with.

B) The home's policy "Continence Care and Bowel Management, NM 03-08-14", last revised August 2015, directed registered staff to complete a "Bowel and Bladder Continence Assessment" on admission, at least every six months, at any other time when the resident's care needs change or care set out in the plan is no longer effective, and with each annual MDS assessment.

i) Review of the resident #005's plan of care revealed that a Bladder and Bowel Continence Assessment had not been completed since December 2014. Interview with registered staff #108 confirmed that Bladder and Bowel Continence Assessments were not completed every six months for resident #005 as required in the home's policy.

ii) Review of the resident #008's plan of care revealed that a Bladder and Bowel Continence Assessment was completed in November 2014 and not again until August 2015. Interview with registered staff #108 confirmed that Bladder and Bowel Continence Assessments were not completed at least every six months for resident #008, as required by the home's policy.

iii) Review of the resident #004's plan of care revealed that a Bladder and Bowel Continence Assessment had not been completed since November 2014. Interview with registered staff #108 confirmed that assessments were not completed every six months for resident #004 as required by the home's policy.

C) The home's policy "Skin and Wound Care, NM 03-08-14", last revised February 2015, indicated that all residents would have their risk for altered skin integrity determined on admission, upon any return from hospital, or upon any return from an absence greater than 24 hours, using the Pressure Ulcer Risk Scale (PURS).

i) In May 2015, resident #012 returned to the home after a stay in the hospital. Review of the plan of care identified that the resident was at risk for altered skin integrity. Interview with registered staff #105 confirmed that a PURS was not completed for resident #012 when they returned from hospital. [s. 8. (1) (b)]

WN #11: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Several days during the course of the inspection, resident #006 was observed sleeping in bed after lunch. Review of the resident's plan of care did not indicate their sleep patterns and preferences. PSW #127 stated the resident was transferred to bed after lunch daily and sometimes after breakfast to rest and sleep. Registered staff #100 confirmed the resident went to bed after lunch and sometimes after breakfast and there was no interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

i) In November 2015, puree tuna sandwich and puree italian mix vegetable were on the planned menu for a lunch meal, but not observed during meal service. Dietary staff #115 reported there was no puree second choice at the meal. PSW #116 who was regular staff also reported there was usually no second puree choice at lunch and no second choice was offered during the observed meal. At the end of lunch, dietary staff # 115 identified the puree choices were available in the joint servery area between two home areas. The dietary services supervisor confirmed the menu items should have been offered.

B) In November 2015, puree bread was on the planned menu for a lunch meal. During a dining observation in a dining room, one small scoop of puree bread was served to residents receiving a puree meal. Review of the production sheet indicated the that two #24 scoops of bread were to be offered as part of the planned menu. Interview with the dietary aide #115 confirmed residents receiving puree bread received one #24 scoop as those residents would not eat the second scoop. PSW #116 placing orders for residents reported they did not request small portions for any puree meals. The dietary services supervisor confirmed two #24 scoops should have been offered as all residents on puree diets in the home area.

C) In November 2015, fresh fruit and toast were on the planned menu for a breakfast meal however not observed in a puree texture during meal service. Dietary staff #117 reported puree fruit or toast was not served when on the menu. Interview with the dietary services supervisor confirmed toast and bread were on the planned menu and should have been available in all textures. [s. 71. (4)]

Issued on this 23rd day of December, 2015

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

Original report signed by the inspector.