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
Nov 24, 2015	2015_270531_0031	O-002870-15	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WEST LAKE TERRACE
1673 COUNTY ROAD, 12 R. R. #1 PICTON ON K0K 2T0

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

SUSAN DONNAN (531), AMBER MOASE (541), DARLENE MURPHY (103)

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 16, 17, 18,19, 20, 23 and 24, 2015

Log # O-002098-15 and Log # O-001385-14 were included in this inspector.

During the course of the inspection, the inspector(s) spoke with residents, resident substitute decision makers, Personal Support Workers, Registered Practical Nurses, Registered Nurses, the Maintenance Supervisor, the Director of Care and the Administrator.

During the course of the inspection,the inspectors toured the home, observed resident care and services, reviewed resident health care records and applicable policy and procedures.

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

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2014_347197_0025	531

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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to resident #041.

The plan of care for resident #041 was reviewed in regards to responsive behaviours. The plan indicated the following:

Physically abusive behaviour:
-always approach from the front; doesn't like to be touched; if agitated when staff approach for care, leave and return at a later time,
-give medication as ordered; 2 staff for all care

Resists treatment or refuses care:
-suggest that you would like to help resident with care as he/she has helped lots of people,
-complete care step by step; ask if you can help; make it about "returning the favour" and not returning help.

The resident progress notes were reviewed and indicated on an identified date, resident #041 was highly resistant during care/ brief change and the resident sustained an injury during the process. PSW #114 was interviewed and indicated the resident was laying awake in bed on or about 0800 hr that day. She indicated that she and PSW #104 proceeded to assist in getting the resident up. PSW #114 stated she advised the resident they would be getting him/her up and recalls the resident tried to hold onto the bed sheets when she went to remove them. According to PSW #114 the resident

became very combative when they attempted to provide him/her with peri care and brief change. PSW #114 stated the resident does sometimes sleep in but she felt that because he/she was awake in bed, at the time she approached the resident, that he/shew ould be cooperative with getting up. PSW #114 also indicated staff do reapproach sometimes when the resident is resistive to care, however she felt because of the incontinence, the care needed to be completed at that time.

PSW #104 was interviewed and stated she recalled that day because it was a bad morning for resident #041 as he/she was very resistant during care. PSW #104 stated it is best to allow this resident to rise later in the day as he/she will be in a better mood and more accepting of care . At the time of the interview (on or about 1030hr), this PSW showed the inspector the resident was still in bed. The resident was observed to be awake, content and was drinking a beverage. PSW #104 was unsure why the resident was not allowed to stay in bed that day and stated she was not assigned to care for him/her but just helping to get the resident up. PSW #108 was also interviewed and stated resident #041 likes to stay in bed until later in the morning and that the resident is much less resistant to care when given the extra time.

RN #111 indicated it would be her expectation that resident #041 would be reapproached if resistant to care unless the staff deemed it to be an emergency.

Resident #041's plan of care failed to outline interventions to reduce the incidents of resistance to care including allowing the resident to stay in bed later in the morning or methods of distracting the resident during care. [s. 6. (1) (c)]

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

The following findings relate to Log #O-002098-15:

Resident #041 had a specified diagnosis and has sustained a number of falls/injuries since being admitted to the home.

The resident plan of care was reviewed and indicated the resident uses a chair alarm as a fall prevention measure when sitting in the wheelchair. On November 23, 2015 on or about 1130, resident #041 was observed to be sitting at the dining room table in the wheelchair without the chair alarm. The wiring was observed for the chair alarm, but the alarm box was not connected. This inspector located the chair alarm box on the

resident's bedside table.

RPN #105 was interviewed and stated she believed the chair alarm had been discontinued because the resident had not been attempting to get out of the wheelchair recently. PSW #108 was interviewed and stated she was unsure if a chair alarm was still being used for the resident. PSW #109 was interviewed and showed this inspector the HCA/PSW assignment sheets which listed chair alarm as a fall prevention measure to be used when the resident is seated in the wheelchair. [s. 6. (7)]

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 resident #041's plan of care is updated to include strategies to reduce incidents of resistance to care, including allowing the resident to rise later in the morning, and methods of distraction during resident care, to be implemented voluntarily.

Issued on this 24th day of November, 2015

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

Original report signed by the inspector.