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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2013	2013_188168_0015	H-000153-13	Resident Quality Inspection

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8, STONEY CREEK, ON, L8G-1G6

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

ARBOUR CREEK LONG-TERM CARE CENTRE
2717 KING STREET EAST, HAMILTON, ON, L8G-1J3

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

LISA VINK (168), GILLIAN TRACEY (130), MARILYN TONE (167), TAMMY SZYMANOWSKI (165)

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): March 19, 20, 21, 22, 25, 26, 27, 28 and April 2, 3 and 5, 2013.

This inspection was conducted concurrently with Complaint Inspections H-002015-12, H-000178-13 and Critical Incident Inspections H-000040-13 and H-000032-13, and contains findings of non-compliance for some of these inspections.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Service Manager (FSM), Director of Recreation and Leisure Services, Wound Care Nurse, Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Chair of Family Council, President of Residents' Council, Environmental Lead Hand, Quality Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), front line staff including Personal Support Workers (PSW), residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all resident home areas and reviewed relevant documents including, but not limited to: policies and procedures, meeting minutes, menus, and health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Food Quality
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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 O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The food production system did not consistently, at a minimum, provided for documentation on the production sheet of any menu substitutions.

Substitutions were not documented on the production sheets. Pancakes were not documented on the production sheets when substituted for waffles and subsequently sufficient quantities were not produced. Fruit cocktail was not documented on the production sheets when substituted for pears. The FSM confirmed that substitutions were not documented on the production sheets. [s. 72. (2) (g)]

2. Not all food and fluids in the food production system were prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality.

A) Recipes for planned menu items were not available and followed by staff and sufficient quantities of food were not available. The FSM confirmed that the recipe for the summer fruit and cottage cheese plate served March 19, 2013, was printed and placed in the recipe binder the following day on March 20, 2013. The summer fruit and cottage cheese plate recipe indicated watermelon and cantaloupe were to be served with cottage cheese, the therapeutic menu indicated watermelon, cantaloupe and grapes were to be served. The FSM confirmed that resident's on the first and fourth floor dining rooms received strawberries and grapes and resident's on second floor received watermelon and cantaloupe as there was not enough fruit available for staff to follow the recipe.
B) The recipe for puree soup was not followed on April 5, 2013. The cook stated that the soup was prepared to nectar consistency and staff confirmed that thickener was added on the floor for resident's that required honey consistencies however; the recipe indicated that staff were to prepare soup to honey consistency.
C) The planned menu indicated that residents were to receive waffles for the lunch meal on March 19, 2013. Resident's on first and fourth floor dining rooms received waffles however; those on second and third floor dining rooms received pancakes. The FSM confirmed that the home did not have enough waffles to serve all residents. There were not sufficient quantities of pancakes to serve the residents in the second floor dining room. Dietary staff called all other dining areas however there were no pancakes left to serve. A resident requested the pancake meal however; the home did not have sufficient quantities to provide the meal.
D) The food committee meeting minutes dated November 28, 2012, raised concerns to the home regarding running out of food and family interviewed during the inspection indicated the home frequently runs short of food.

E) The FSM confirmed that shortages are not consistently tracked in each dining room and the cook confirmed that the main kitchen did not track food shortages. Production sheets were not adjusted to reflect changes in production.
F) Consistencies of puree foods were not prepared to preserve taste and nutritive value. The consistency of puree menu items prepared March 19, March 26 and April 5, 2013, were not of a cohesive texture. The cook stated that foods were prepared by adding water and thickener as needed and the puree fruit compote was prepared cold and then placed in the steam cart which contributed to the texture.
G) Portion sizes for the planned menu were not always followed which did not preserve the nutritive value of the planned menu items. During the lunch meal April 5, 2013, staff served portion sizes that were less than those listed on the therapeutic menu. For example, the therapeutic menu indicated a #12 scoop was to be used for the puree sausage however; a #16 scoop was used instead. The recipes for minced and puree salad indicated the portion sizes for staff to be used were #10 scoop, however; the therapeutic menu indicated portion sizes for staff to be used were #16 scoop. Thus resulting in not all foods were not served to preserve nutritive value. [s. 72. (3) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Not every written plan of care, for each resident, set out the planned care for the resident.

A) Resident #056 returned from the hospital in 2013, with device in place. The plan of care reviewed on March 22, 2013, did not include the need for the device or relevant interventions for use, including for the area to be kept dry during bathing activities. This omission was confirmed during an interview with staff.
B) Resident #056 was observed on March 22, 2013, wearing specialized footwear when up in the wheelchair. The clinical record and resident interview identified that the use of the footwear was a new intervention due to altered skin integrity. The use of the footwear was not included in the plan of care. [s. 6. (1)]

2. Not all plans of care set out clear directions to staff and others who provided direct care to the resident.

A) The plan of care identified responsive behaviours for resident #006 towards other residents when they entered the bedroom. The plan stated that a yellow banner was to be in place on the resident's doorway to deter co-residents from wandering into the room. The banner was not observed in place on March 20 and 26, 2013. Staff interviewed confirmed that the banner was only used when the home area included residents who wander into the resident's room and not all of the time. The plan did not give clear direction to staff regarding when to use the banner.
B) The plan of care for resident #025 did not provide clear direction regarding weight bearing status or level of assistance related to transferring. The plan indicated two staff were required to transfer with a full sling mechanical lift and non weight bearing; however, also stated required weight bearing support and a sit to stand lift for transfers. According to the plan the resident was at high risk for fractures related to a diagnosis and staff were to monitor for increased complaints of pain or inability to weight bear; however, also that the resident was unable to weight bear. Staff interviewed confirmed that the resident was non-weight bearing and required a full sling hoyer lift for all transfers.
C) The plan of care for resident #025 directed staff to wash the resident's hair on Thursday's only; however, it also indicated they did not like their hair washed and liked a salon wash on Friday, hair appointment day. [s. 6. (1)]

3. Not all 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 complemented each other.

A) Resident #056 had a Quarterly Review Assessment on May 22, 2012. This assessment identified behaviours exhibited by the resident and the frequency. A Quarterly Review Assessment of August 7, 2012, identified that the resident continued to exhibit the same behaviours during the quarter, however at an increased frequency. The August 2012, assessment noted that the resident had no change in symptoms and that the change in the resident's mood had improved over the past 90 days. Interview with staff confirmed that the two assessments conducted did not complement each other.
B) The plan of care, for resident #006, revised on February 1, 2013, noted that the resident wore correctional lenses everyday to see clearly. The Quarterly Review Assessment for March 5, 2013, noted that the resident did not use glasses. Interview with staff confirmed that the resident did have glasses and that they are usually with the resident, but were rarely used. The information in the plan was not consistent with the Quarterly Review Assessment completed.
C) Resident #101 had a history of exhibiting responsive behaviours. The Quarterly Review Assessment of January 8, 2013, (with the seven day observation period ending January 8, 2013, according to the assessment) identified that the resident displayed behaviours including wandering, verbally abusive, socially inappropriate/disruptive and resistant to care from one to six times, during the observation period. According to the "PSW Documentation Record" for the same period of time the resident did not display any of the behaviours identified. The resident did not have any other record of behaviours in the progress notes nor was there a behavioural tracking record, during the observation period. The assessment dated January 8, 2013, was not consistent with the information provided by other staff.
D) Resident #056 had a Quarterly Review Assessment, on December 18, 2012. The Minimum Data Set (MDS) coding of this assessment, under skin conditions, noted that the resident had one stage I ulcer and two stage II ulcers, due to pressure. The Resident Assessment Protocol's (RAP's) completed during this assessment contained conflicting information. The RAP completed related to nutritional care identified that the resident had two identified skin issues and that one ulcer had healed. The combined RAP for urinary incontinence and pressure ulcers identified a stage I ulcer and that a second area wound was dried up now. The MDS assessment completed was not consistent with the skin conditions identified in the RAP's, nor was the nutritional care RAP consistent with assessment conducted by nursing staff.
E) The MDS Annual Assessment, dated March 12, 2013, included a Cognitive/Loss

Dementia RAP, which identified that resident #025 refused a chair alarm. The Falls RAP completed for the same time period indicated a chair alarm was used every day to prevent falls. This RAP also indicated the resident toileted and dressed self almost every day after breakfast; however, the Activities of Daily Living (ADL) RAP indicated required extensive assistance to total assistance with most of ADL's which included toileting and dressing.
F) Resident #554 sustained three falls early in 2012. According to the plan of care the resident was identified as a high risk for falls, however, the annual assessment completed on May 15, 2012, did not identify the resident was at risk for falls, nor was it identified that the resident had sustained falls in the previous 180 days. Staff confirmed that the records reviewed did not complement each other.
G) The MDS assessment completed with the last date of observation period of December 18, 2012, for resident #025 did not indicate that the resident had insufficient fluid provided during the last three days, as stated in the assessment, and a RAP summary for dehydration/fluid maintenance was not completed. The daily food and fluid intake records for the time period dated December 16 - 18, 2012, indicated the resident consumed less than six glasses per day, half of the resident's identified fluid goal. The dietitian assessment completed December 21, 2012, indicated the fluid intake was low (consumed three to six glasses/day) and the resident was at risk of dehydration. There was no collaboration between nursing staff who completed the MDS assessment and the dietitian. The resident's food and fluid intake records indicated fluid consumption continued to be poor and the resident was transferred to hospital for dehydration.
H) The MDS assessment for resident #056 dated May 22, 2012, identified under "continence self-control categories" that the resident was incontinent of bladder, however the same assessment included a catheter for urinary drainage. The assessment completed was not clear regarding the resident's continence status, which was confirmed by the RAI coordinator. [s. 6. (4)]

4. Not all care set out in the plan of care was provided to the resident as specified in the plan.

A) The plan of care for resident #056 stated "mouth care three times a day after meals to make sure no food debris in mouth before going to bed". During interview with the resident and staff it was confirmed that the resident did not consistently receive oral care as per the plan. The resident reported that no oral care was provided on March 22, 2013, by the day shift as late as 1358 hours. The resident's

toothbrush was monitored at 1055 and 1358 hours on March 22, 2013, and both times was noted to be dry and caked with toothpaste. The resident was observed on March 20 and 22, 2013, and was noted to have a cream coloured substance, built up, on the teeth.
B) Resident #744's plan of care, dietary listings and daily food and fluid intake record indicated the resident was to receive a great shake supplement for lunch meals. The resident did not receive a great shake for the lunch meal on March 19, 2013. The resident's daily food and fluid intake record indicated the great shake was not available and staff confirmed it was not available nor provided to the resident.
C) Resident #056 had a specific diagnosis and the dietitian identified the need for increased protein needs related to the diagnosis, blood work results and assistance in wound healing. The resident had a physician's order for one scoop of protein powder three times daily with meals however; the RN and the resident confirmed it was not provided on March 27, 2013, during the lunch meal because the registered staff ran out. Staff confirmed that protein powder was not provided to the resident from March 27 until April 2, 2013, because the protein powder was not replaced on the floor. The FSM confirmed the main kitchen did not have protein powder however; it was available on other floors. Documentation in the resident's Medication Administration Record (MAR) indicated the protein powder was unavailable starting March 26 to April 2, 2013.
D) Residents #606, #607, #608 and #609 were deemed high nutritional risk by the dietitian and had plans that directed staff to provide great shake nourishments at afternoon snack pass. However the nourishments were not labeled and prepared on the cart for staff to provide and the residents did not receive their individualized shakes on March 22, 2013.
E) Residents #554 and #611 were deemed high nutritional risk by the dietitian and had plans that directed staff to provide ice cream/high energy high calorie pudding or pudding at the afternoon snack pass. However the nourishments were not labeled and prepared on the cart for staff to provide and the residents did not receive their individualized snacks on March 22, 2013. The FSM confirmed that these items were not prepared for distribution. [s. 6. (7)]

5. Not all staff and others who provide direct care to the resident, were kept aware of the contents of the plan of care or did not have convenient and immediate access to it.

A) The document that the home referred to as the care plan, in the care plan binder for resident #002 on March 25, 2013, did not contain the most current information.

The plan that was accessible to the PSW's was not updated when the resident returned from hospital. This plan was dated as last reviewed on January 15, 2013, when the resident was in hospital and plan indicated monitoring/checking every hour using the "Behaviour Observation Record". The electronic plan had been updated after the resident returned from hospital, but was not printed or available to provide direction to staff related to the resident's care needs. This updated plan directed staff to monitor the resident's behaviour every 30 minutes and to chart hourly on the "Behaviour Observation Record". It was confirmed that the PSW's did not have access to the home's computerized care plans.
B) Resident #056 had a plan of care in the flow sheet binder with a print date of July 13, 2012. This plan was not the same, as the plan in the computer. The plan in the computer was amended to included changes to a number of focus statements including recreational needs, oral care and skin and wound care needs. Front line staff did not have convenient and immediate access to the current plan of care.
C) The printed plan of care available to staff March 22, 2013, for resident #744 had different focus/goals/interventions then the computerized plan of care in the identified areas of nutritional status, falls and skin integrity. [s. 6. (8)]

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 for LTCHA, 2007 s. 6(1)a, 6(1)c, 6(4)a, 6(7) and 6(8), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. Not all residents were provided with foods and fluids that were safe, adequate in quantity, nutritious and varied.

A) Resident #744 received thin apple juice and water for the lunch meal on March 19, 2013. The resident was fed thin fluids via a straw and was observed coughing post drinking. The resident had recommendations from a speech language pathologist for nectar thickened fluids via a teaspoon. Staff confirmed that the resident had been receiving thin fluids despite the physician's order for nectar thickened fluids.
B) The home did not have adequate quantities of regular pancakes during the lunch meal on March 19, 2013, and staff confirmed there were no pancakes in all home areas. A resident did not receive their choice of a pancake meal and as a result only consumed a muffin, for the lunch meal. The food committee meeting minutes dated November 28, 2012, raised concerns regarding running out of food and family interviewed during the inspection indicated the home frequently runs short of food. [s. 11. (2)]

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 residents are provided with foods and fluids that are safe, adequate in quantity, nutritious and varied, to be implemented voluntarily.

WN #4: 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. Not all furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) Wall damage as evidenced by scratches, scuffs, evidence of patching without repainting, dents in wall board, missing or broken tiles in the spa areas and ripped/peeling wall paper was identified in a number of areas throughout the home in resident rooms and common areas during the course of the inspection. The Environmental Lead Hand confirmed knowledge of the damage and identified plans to repaint a significant portion of the home by the end of the year. It was identified that some of the areas of concern had previously been repaired or repainted however due to resident or staff action further damage had resulted.
B) Ceiling tiles were noted to be discoloured, with evidence of water damage in rooms numbered 416, 215 and 206. The Lead Hand was aware of the condition of the tiles and identified that the cause of the damage had since been corrected and plans are in place to replace these tiles.
C) Some carpeting on the second and third floors were noted to be stained or evidence of wear patterns. Interview with the Lead Hand confirmed plans to begin a flooring replacement project in June 2013, including the second, third and fourth floors for the common areas and hallways and the first floor the dining and lounge area.
D) A number of wooden surfaces in the home including: furniture (dining room table and chairs) and fixtures (hand rails, built in television cabinets, half walls between columns in lounge areas) were noted to have worn surfaces, without a consistent finish, leaving areas of exposed wood, uneven finishes and making the areas difficult to effectively clean. Interview with the Lead Hand confirmed knowledge of the condition of the surfaces identified, however at this time no plans had been been finalized to address this concern. [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 that all furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. Not all staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Resident #070 was observed on March 19, 2013, at approximately 1045 hours and again on March 26, 2013, following the noon meal to be up in the wheelchair wearing a side fastening seat belt. The belt was noted to be loose fitting, approximately the distance of four fingers width between the belt and the resident's abdomen. Staff tightened the belt following the issue being identified by the Inspector on March 26, 2013. Staff confirmed that the use of the device was a Personal Assistance Services Device (PASD) and that it was not applied according to manufactures' instructions, which was to be secured snugly around the resident, approximately the distance of two finger widths between the resident and the abdomen. [s. 23.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

A) The plan of care for resident #002 initiated in February 2013, directed staff to monitor the resident every 30 minutes and to chart hourly on the "Behaviour Observation Record". A staff member interviewed confirmed monitoring of the resident every 30 minutes and documentation on the "Behaviour Observation Record". During a review of the "Behaviour Observation Record" it was noted that the documentation related to monitoring was not consistently completed. On the following dates there was no documentation on the "Behaviour Observation Record" related to monitoring activities:
i) February 15, 2013 - no documentation between 0315 and 0700 hours.
ii) February 16, 2013 - no documentation between 1315 and 2245 hours.
iii) February 17, 2013 - no documentation between 1315 and 2300 hours.
iv) February 18, 2013 - no documentation between 1200 and 1430 hours.
v) February 18, 2013 - no documentation between 1630 and 2245 hours.
Staff interviewed confirmed that monitoring of the resident did occur, however was not documented.
B) The plan of care for resident #056 indicated a number of treatments were to be completed to areas of altered skin integrity in January and February 2013. Treatment Administration Records (TAR) were reviewed for January and February 2013, and a number treatments were not signed as being completed on specified dates/shifts. Interview with the wound care nurse confirmed the omissions on the TAR's and indicated that if the time/date box was blank, staff failed to sign for the administration/completion of the treatment.
C) Resident #744 had a physician's order to cleanse a stage II wound and provide a dressing every three days however; the TAR did not include documentation from registered staff that the ordered treatment was provided on May 1 and June 18, 2012. The wound care nurse confirmed that registered staff did not document treatment was provided as ordered on these days.
D) Resident #056 had a physician order for insulin to be administered, four times daily, however the dosage would vary. The RPN confirmed that documentation of the dosage of insulin provided to the resident was not recorded on the MAR. Review of the MAR revealed that the dosage had not been documented at least 60 times in March 2013.
E) Resident #056 had a blood sugar of 3.7 millimole/litre (mmol/l) February 25, 2013,

at 1653 hours however, the RPN confirmed that there were no interventions documented in the resident's clinical health record despite experiencing a low blood sugar. The RPN confirmed that interventions provided to the resident, when they experienced low blood sugars, were to be documented in the clinical health record. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions are documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The falls prevention and management program to reduce the incidence of falls and the risk of injury was not fully implemented.

The Falls Prevention Program, "Policy No. 04-09-13B" indicated:
1) Registered staff to ensure that the care plan addressed resident level of risk. If the resident's level of risk was high, registered staff were to implement high risk prevention strategies such as placing high risk signage by the bed.
"Policy No. RC-09-02-01" indicated:
1) Registered staff were to check resident's vital signs including Capillary Blood Glucose (CBG) (even if resident was not diabetic).
2) Registered staff were to complete incident report, monthly resident summary form, and detailed progress notes.
3) Registered staff were to call for a post fall conference to investigate and discuss interventions to prevent future falls.
4) For the 48 hours following the fall:
i) Obtain vital signs every eight hours.
ii) Document in resident progress notes every shift.

A) The plan of care for resident #025 indicated a high risk for falls; however staff confirmed there was no signage in the resident's room. According to the plan of care, the resident sustained five falls in 2012 and two in 2013. CBGs were not obtained for any of the recorded falls and staff interviewed confirmed that they were not obtained as part of the post fall assessment. Post fall assessments, risk assessments, conferences and documentation in progress notes for 48 hours following the falls, were not consistently completed.
B) Resident #554 sustained three falls in 2012. According to documentation reviewed and staff interviewed, staff did not check the resident's CBG following the incidents, post fall conferences were not consistently held nor was the resident consistently monitored for 48 hours post fall. [s. 48. (1) 1.]