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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 12, 2016	2016_337581_0010	020239-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CORPORATION OF NORFOLK COUNTY
50 Colborne Street South SIMCOE ON N3Y 3H3

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

NORVIEW LODGE
44 ROB BLAKE WAY P. O. BOX 604 SIMCOE ON N3Y 4L8

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

DIANNE BARSEVICH (581), BERNADETTE SUSNIK (120), CYNTHIA DITOMASSO (528), LEAH CURLE (585)

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): July 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2016.

During the course of this inspection the following inspections were conducted concurrently:
Critical Incident Inspections
006188-15- related to falls prevention

035152-15- related to falls prevention
001956-16-related to falls prevention
016929-16- related to falls prevention
018414-16- related to an unknown injury
019655-16- related to falls prevention
035703-15- related to alleged abuse
003137-16- related to responsive behaviours
005170-16- related to infection,prevention and control
007240-16- related to unexpected death
007796-16-related to bathing and personal care
013123-16- related to pain management and transfer and positioning techniques

Follow-Up Inspection
006057-16-related to inspection number 2015_322156_0023 related to r.(15)(1)-bed rails.

On Site Inquiries
035425-15-related to falls prevention
006190-15-related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing and Personal Care, Resident Care Coordinator (RCC), Resident Assessment Instrument (RAI) Coordinator, Nurse Practitioner (NP), Registered Nurses (RN), Registered Practical Nurses (RPN), Programs/Volunteer Supervisor, Nutritional Service Supervisor (NSS), Registered Dietitian (RD), Facility Service Supervisor (FSS), Personal Support Workers (PSW), dietary staff, housekeeping staff, residents and families.

During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, tested the resident-staff communication and response system, measured illumination levels, reviewed relevant documents, including but not limited to, policies and procedures, meeting minutes, investigative notes, bed system evaluation records, bed safety assessments and clinical records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
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
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **5 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
O.Reg 79/10 s. 15. (1)	CO #001	2015_322156_0023	120

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 sets out the planned care for the resident.

Review of the plan of care for resident #004 identified they were occasionally incontinent of bowel and incontinent of bladder. Interview with registered staff #113 and PSW #100 both stated the resident was on a toileting schedule and was toileted with one staff when they got up, before they went to bed and before or after lunch and that they often toileted themselves during the day. Review of the written plan of care did not identify they were on a toileting schedule as planned care and confirmed by registered staff #113. [s. 6. (1)

(a)]

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

A. Review of the Minimum Data Set (MDS) assessment in April 2016, for resident #004 indicated they had impaired vision and would see large print, not regular print in newspapers or books and they did not wear glasses. Review of the written plan of care identified that staff were to ensure their reading glasses were clean, in good repair and were to be worn when reading. Review of the Resident Assessment Protocol (RAP) in April 2016, revealed that resident #004 was responding to the interventions as outlined in the written plan of care. Interview with resident #004 and PSW #100 both stated that they wore glasses when reading and their reading glasses were observed in their room. Interview with registered staff #101 stated that the resident did wear glasses for reading and confirmed that the MDS assessment, RAP and the written plan of care were not consistent with each other.

B. Resident #006's MDS assessment from April 2016, indicated in coding under Section E: Mood and Behaviour Patterns, that they resisted care on one to three days in the last seven days which was not easily altered, and experienced a deterioration in their behavioural symptoms compared to their previous MDS assessment in January 2016. Review of the flow sheets completed by staff during the assessment review date (ARD) period in April 2016, indicated that they did not demonstrate any resistance to care. Review of the plan of care indicated they would refuse/resist oral care. Interview with PSW #128 reported the resident never resisted care. Interview with registered staff #132 reported the resident would refuse care which was different from resistance to care and confirmed the MDS assessment from April 2016, was not consistent with the assessment completed by staff during the ARD period. (585) [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. In February 2016, resident #026 began displaying new respiratory symptoms. As a result, the Nurse Practitioner (NP) ordered registered staff to take the resident's vital signs over the next three days and ordered a diagnostic test. Review of the plan of care did not include vital signs for one out of the three days, as ordered. Furthermore, the

diagnostic test was not completed. A week after the initial order, the diagnostic test was reordered by the physician. Review of the progress notes, vital signs documentation, diagnostic reports and interview with registered staff #129 confirmed the plan of care was not provided to resident #026, related to NP orders.

B. Resident #001 fell on an identified day in January 2016 and sustained an injury. Review of the post fall assessment indicated that an intervention to prevent falls was not in place at the time of the fall. Review of the PSW flow sheets on an identified day in January 2016, on night shift revealed it was not signed that staff checked that the falls intervention was in place. Interview with registered staff #108 stated that the falls intervention was to be in place and confirmed the falls intervention was not in place which was planned care. (581) [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

A. Resident #001 sustained an unwitnessed fall on an identified day in November 2016 and review of the progress notes indicated that a falls intervention was put in place as an intervention for falls management. The resident fell again on an identified day in November 2016 and the post falls assessment identified that the falls intervention was not implemented at the time of the fall. Review of the PSW flow sheets revealed that the falls intervention was not on their flow sheets until three days later. Interview with registered staff #108 confirmed that the plan of care was not reviewed and revised when the falls intervention was put in place.

B. Review of the plan of care for resident #006 identified that they were diagnosed with an injury on an identified day in April 2016 and the cause was unknown. They were readmitted to the home eight days later and were assessed as a significant change in status. Review of the RAP identified they now required increase in assistance with activities of daily living, including but not limited to, dressing, bed mobility, transfers, walking in the corridor and toilet use. Review of the written plan of care last updated on an identified day in April 2016, indicated that it was not reviewed and revised when their care needs changed related to an injury and this was confirmed by registered staff #114.

C. Review of the plan of care for resident #033 indicated that the resident walked in their room independently and required set up help with an assistive device. Interview with PSW #100 and resident #033 stated that they no longer walked in their room independently and only walked during their rehabilitation program. Interview with

registered staff #122 stated that the resident no longer walked independently due to risk of falling and confirmed that the written plan of care was not revised when their care needs changed related to ambulation.

D. Review of the plan of care for resident #035 identified they had an injury and were transferred to the hospital. They returned to the home on a specific treatment plan due to their injury. Review of the written plan of care indicated that the resident was to be transferred with the maxi sling into their wheelchair. Interview with registered staff #114 stated the resident was on a specific treatment plan and was no longer being transferred and confirmed that the written plan of care was not revised after their care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care is reviewed and revised when the resident's care needs changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, that the resident was assessed in accordance with evidence-based practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care (LTC) Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document included the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggested that the documents were "useful resources". Prevailing practices included using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents were also prevailing practices and provided necessary guidance in establishing a clinical assessment where bed rails were used.

One of the companion documents was titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations were made that all residents who used one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails (medical device). To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) were a safe device for residents while in bed (when fully awake and while they were asleep).

The Clinical Guidance document also emphasized the need to document clearly whether alternative interventions were trialed, if bed rails were being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails were considered for transferring and bed mobility, discussions needed to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which would more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the

type of bed rail required (rotating assist rail, quarter length, 3/4 length), when the bed rails were to be applied (when in bed, throughout the day, when being re-positioned), how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed fully in accordance with the Clinical Guidance document identified above. According to the Director of Nursing and Personal Care, the Clinical Guidance document was reviewed and incorporated into their existing questionnaire titled "Bed Rail Assessment" dated February 3, 2016, which was used to assess residents for bed rail use/safety.

Bed rail safety assessments were reviewed for five residents who were observed to be either in bed and had one or more bed rails in use or had bed rails elevated on their beds and a care plan requiring them to have at least one bed rail in use while in bed.

A. The assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours would be evaluated or observed while sleeping in bed with or without the application of bed rails. The licensee's policy titled "Bed Rail Assessment- Nursing" dated February 3, 2016, did not identify when residents would be monitored after admission, for how long and by whom. The policy directed the registered staff to complete the assessment upon admission (and quarterly after admission or when a change occurred, either to bed or with resident). The Bed Rail Assessment form did not include any information regarding how long residents were observed and by whom, the dates that they were observed and the specific behaviours that were monitored during a specified observation period.

B. The Bed Rail Assessment form did not include a section that would be completed by the assessor indicating what bed rail alternatives were trialed and if successful or not prior to applying the bed rails, if they were indicated for a medical symptom or condition. The policy included direction for the registered staff to review alternatives with the resident or the SDM; however, there was no direction for the registered staff to document the outcome. The options included bed exit alarm, call bell placement, increased monitoring, call bell availability, bed rail pads, bed in the lowest position, removing bed rails, mattress change, fall mats and re-arrangement of room. The options listed were for the most part interventions to prevent falls from bed and not necessarily related to bed rail alternatives such as a transfer pole, adjustable bolsters or teaching the resident new

transfer or re-positioning techniques.

C. The Bed Rail Assessment form did not include any questions related to the resident's sleep patterns, behaviours, falls history, cognition, history of bed rail use, medication use and mobility. These questions were included in the policy, and they were to be used to direct the assessor (RN) in completing their assessment; however, there was no direction to document the information and the Bed Rail Assessment form did not include the answers to the questions.

D. The Bed Rail Assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. Resident #004, resident #005, resident #006, resident #050 and resident #051 assessment forms were reviewed and included the name of the registered staff member only. The home's policy referred to the role of the registered staff in completing the assessment and did not include any other persons who would be able to assist and would have knowledge of the resident's behaviours, mobility and sleep patterns and habits such as Personal Support Workers (PSW) and Physiotherapists.

E. Health care staff or PSW's did not follow the written plan of care or the information was not clear regarding bed rail use.

During a tour of the home, it was noted that many resident beds (1424, 1410 (both), 1414 (both), 1447, 1435 (both), 1441(both), 1545, 1543, 1539, 1537(both), 1518 (both), 1512), which were unoccupied at the time of the visit, had one or both rotating assist rails in the guard position. The majority had the bed rail in the guard position and sometimes covered with a blanket on the window side of the room. When a PSW was asked why bed rails remained in the guard position when unoccupied, they replied that it varied, depending on each PSW, but in some cases was related to habit.

The written plan of care for five residents noted residents were reviewed and each indicated that at least one bed rail was required in the guard position. Some of the reasons given included safety/security, comfort and/or repositioning. A definition of safety or security was not included in the home's policy. The term "safety" would need to include what unsafe condition was being prevented if the bed rails were to be applied.

The written plan of care was reviewed for resident #050 who had both bed rails in the guard position and was not in bed at the time of observation on July 21, 2016. The most current written plan of care directed staff to apply the left bed rail in the assist position (up

near the head of the bed) for transferring in and out of bed and the right in the guard position (centre of bed) for bed mobility and repositioning. There was no direction in the written plan of care to leave both bed rails in the guard position. A registered staff member was asked if there was an alternative method of knowing when to apply the bed rails and a "treatment sheet" was presented. The sheet required that PSWs signed for each day and each shift if the treatment identified was provided. For this particular resident, the treatment sheet for the month of July did not identify that the resident required bed rails. Information about the resident's day to day needs was also included on a sheet titled "ADL Functional Status". It included a condensed version of information found in the written plan of care; however, no bed rail use requirements were listed on this resident's Activity of Daily Living (ADL) Functional Status sheet.

Resident #006 was not in the bed at time of observation on July 21, 2016; however, both of the bed rails were in the guard position. The resident's most current written plan of care identified that the resident required both bed rails in the guard position to assist with bed mobility. The resident's Bed Rail Assessment dated in April 2016, included that the bed rails were to be in the guard position on both the left and right side and would be used for "repositioning". Although, not specified in the plan of care or the assessment, it was assumed that the bed rails were to be applied while the resident was in bed and at no other time. The resident's "treatment sheet" for the month of July 2016, indicated that both the right and left bed rails were to be in the guard position and staff signatures were observed to be completed for the night, evening and day shifts. Based on the "treatment sheet" and the Director of Nursing and Personal Care, the direction for staff was to leave the bed rails in the guard position all day, whether the resident was in bed or not. Neither the written plan of care nor the assessment included whether the bed rails were to be applied at night, during the day or with supervision. With the application of both bed rails in the guard position throughout the day, it would be difficult for the resident to enter the bed independently.

Discussion was held with the Director of Nursing and Personal Care regarding the above noted observations and the position they had taken with respect to SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, that the resident is assessed in accordance with evidence-based practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the home's policies identified that when a resident had fallen, registered staff were to assess the resident using the following clinically appropriate assessment instruments:
i. The home's policy, "Fall Prevention and Management", last revised February 2016, identified that when a resident had fallen, they would be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs and complete a Head Injury Routine (HIR) as per protocol.
ii. The home's policy, "Head Injury Routine", revised December 2015, indicated that the head injury routine was initiated for all unwitnessed falls and the Neurovital Signs Sheet was to be completed every hour for three hours, every two hours for three hours and every four hours for 24 hours.

iii. The resident was to be monitored every four to 24 hours and charted on the next three shifts following the fall.

A. Resident #001 had multiple falls between November 2015 and January 2016, with the fall in January 2016, resulting in an injury. Review of the plan of care identified the following:
i. The HIR was not completed post unwitnessed fall on three identified days in November 2015 and on one identified day in January 2016.
ii. The post fall follow-up note was not completed for three shifts after the fall in November 2015, on night, day and evening shifts and after the next two falls on identified days in November on night shift.

Interview with registered staff #108 and registered staff #133 confirmed that the resident #001 was not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Falls Prevention and Management Policy and the Head Injury Routine Policy after resident #001 sustained multiple falls with one fall resulting in an injury.

B. Resident #033 had several falls between December 2015 and May 2016. The fall in May 2016, resulted in the resident being transferred to hospital due to an injury. Review of the plan of care identified the following:
i. The HIR was not completed post unwitnessed fall on an identified day in December 2015, March April and May 2016.
ii. The post fall follow-up note was not completed for three shifts after the fall in March 2016, on night and evening shifts, after the fall in April 2016, on evening shift and in May 2016, on day shift.

Interview with registered staff #114 and registered staff #122 confirmed that the resident #033 was not assessed using a clinically appropriate assessment tool that was designed for falls as outlined in the home's Falls Prevention and Management Policy and the Head Injury Routine Policy after resident #033 sustained multiple falls with one fall resulting in an injury.

C. Resident #020 had multiple falls between December 2015, to June 2016. Review of the plan of care identified the following:
i. The post fall follow-up noted was not completed on night shift after the fall on an identified day in April 2016 and on evening shift after the second fall in April 2016.

Interview with registered staff #114 confirmed that follow up documentation following the resident's falls did not include one out of three shifts for two falls, as required in the home's policy. (528) [s. 49. (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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, 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,
(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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

The plan of care for resident #007 identified that the resident was at high risk for altered skin integrity related to immobility and incontinence as evidenced by recurrent areas of altered skin integrity. In April 2016, registered staff documented that the resident had an area of redness to a specified area. Five days later, PSW staff documented that the specified area was now open. No weekly assessments were included as part of the plan of care for three weeks. On the third week, registered staff documented that their skin was intact. Interview with registered staff #118 confirmed that weekly assessments of the resident's specified area were not completed in April and May 2016, for resident #007, as required. [s. 50. (2) (b) (iv)]

2. The licensee failed to ensure that the resident who was dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load and while asleep if clinically indicated.

The plan of care for resident #007 identified that the resident was at high risk for occurrence for altered skin integrity related to chair fast, extensive assistance required for bed mobility and incontinence. Interventions, included but were not limited to, repositioning of resident in bed and in wheelchair every two hours. On July 25, 2016, the resident was observed in an upright seated position from 1200 to 1530 hours. After three and a half hours, registered staff repositioned the resident in their chair. Interview with registered staff #119, confirmed that the resident had recurrent altered skin integrity to a specified area and required repositioning every two hours. On July 25, 2016, resident #007 was not repositioned every two hours in their wheelchair, as required in the plan of care. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the 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 and that the resident who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load and while asleep if clinically indicated, to be implemented voluntarily.

WN #5: 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 participate in the implementation of the infection prevention and control program.

A.. During the course of the inspection, a urinal was observed on the back of the toilet in the shower room on Maple Crescent home area for eight days. The urinal appeared to be used, was unlabelled and had brownish/black build up on the inside of the container. The home's policy "IFC-10 Cleaning and Disinfection of Medical and Care Equipment", last revised November 2015, identified that urinals should be reserved for single use of a

resident, labelled appropriately and stored in a manner which prevented other use by or for other residents and cleaned after each use or as needed. On the eighth day of observation, interview with housekeeping staff #121 confirmed that the urinal was not clean or labelled. Interview with registered staff #129 confirmed that the urinal was a single use item and was to be labelled, cleaned after each use and discarded if required. The home did not ensure that the urinal was labelled, cleaned and stored in a manner that complied with the home's policy.

B. The home's policy "IFC-29 Hand Hygiene Program", last revised November 2015, directed staff to complete hand hygiene based on the "4 Moments of Hand Hygiene"; before initial resident or resident environment contact, before aseptic procedures, after body fluid exposure risk, after resident or resident environment contact. Other indicators included but were not limited to, before preparing handling or serving food or medications.

On July 19, 2016, during initial observation of lunch service, two out of five staff members did not complete hand hygiene consistently between clearing residents dirty cups and dishes and serving residents the next course. Interview with registered staff #104 confirmed that hand hygiene was to be completed between clearing residents' dirty cups and dishes and serving residents the following course, as required in the home's Infection Control Program.

C. The home's policy "IFC-66 Respiratory Influenza Outbreak Contingency Plan, last revised November 2015" identified that residents with acute respiratory symptoms or influenza like symptoms needed to be isolated to maintain a two meter spatial separation between the coughing resident and others. Routine practices and additional precautions of droplet and or contact precautions would be initiated.

On an identified day in February 2016, resident #026 developed a new respiratory symptom. Over the next two weeks, registered staff documented ongoing symptoms, including but not limited to, shortness of breath, labored breathing, dry cough. On an identified day in February 2016, registered staff documented the resident had a temperature and lethargy, which continued over the next few days. Review of the plan of care revealed that the resident continued to eat in the dining room with co-residents until the resident was placed on isolation precautions two days later. Interview with registered staff #129 confirmed that resident #026 was not placed on isolation precautions when they began displaying infectious symptoms. [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 there were none, in accordance with prevailing practices; and the symptoms were recorded and that immediate action was taken as required.

The home's policy "IFC-36, Infection Prevention and Control (IPAC) Data and Surveillance", last revised November 2015, identified that when it was noted that a resident had signs or symptoms of and or actual infection, registered staff were to document signs and symptoms of onset of symptoms, IPAC measures implemented and follow up information. The Resident Care Coordinator was to review the residents' documentation, doctors orders and surveillance of infection.

In February 2016, resident #026 developed symptoms of infection, including but not limited to cough, shortness of breath, lethargy and temperature. Approximately, two weeks later they were diagnosed with a respiratory infection. Review of the progress notes from onset of the symptoms did not include monitoring and recording of those symptoms every shift, as required in the home's policy. Interview with registered staff #129 confirmed that staff did not consistently monitor and document the resident's infectious symptoms. [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 to ensure that staff participate in the implementation of the infection prevention and control program and that on every shift, 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 the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #6: 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 where the Act or Regulation required, any plan, policy, protocol, procedure, strategy or system in place was complied with.

As part of their Nutrition Care and Hydration program, the home's process for dining service, as reported by the Nutritional Services Supervisor (NSS) and as outlined in a document, "Meal Time Departmental Duties" and staff education slides, identified nursing staff were to assist residents to the dining room 15 minutes prior to meals, then proceed to deliver beverages to the residents in the dining room and stated that drinks were not to be placed on the table prior to the resident arriving.

i. On July 19, 2016, during a lunch observation, residents on Spruce Court home area were observed present in the dining room at 1130 hours with drinks served. Lunch in the home area was scheduled for 1215 hours. Residents were observed attempting to leave the dining room and staff were encouraging residents to stay for over 45 minutes, before lunch was served after 1215 hours.

ii. On July 25, 2016, at 1650 hours, the majority of residents in the Norfolk Pinery home area were observed seated in the dining room for dinner and drinks were set out for residents who had yet to arrive. PSW #136, who was regular staff, reported it was routine practice for drinks to be set out before residents arrived and dinner was not scheduled to begin until 1715 hours.

iii. On July 25, 2016, at 1655 hours, the majority of residents in the Willow Walk home area were observed seated in the dining room for dinner with drinks distributed to the residents. PSW #117 and #137 reported residents began entering the dining room at 1620 hours and dinner was not scheduled to begin until 1715 hours.

Interview with NSS confirmed that drinks were expected to be served only when residents arrived to the dining room and residents were to be portered in no more than 15 minutes prior to meal service. [s. 8. (1) (b)]

WN #7: 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.

On July 19, 2016, each of the resident home areas on the first floor were observed to have a small patio enclosures that were not equipped with a resident-staff communication and response system. During the course of the inspection, residents were observed using the enclosed areas. Interview with the Facilities Services Supervisor (FSS) confirmed that the four small patio enclosures on the first floor (one on each home area) had not been equipped with a resident-staff communication system. [s. 17. (1) (e)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

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

The home was built prior to 2009 and therefore the section of the lighting table that was applied was titled "All other homes". A hand held light meter was used (Sekonic Handi Lumi) to measure the lux levels in several transitional areas in corridors. The meter was held a standard 30 inches above and parallel to the floor as per the Illuminating Engineering Society of North America. Window coverings could not be drawn in some areas as they were ineffective at keeping natural light out of the area being measured. In some areas being measured, the natural light did not affect the readings due to distance from windows. Lights were verified to have been on for more than five minutes prior to measuring. Outdoor conditions were bright during the measuring procedure and natural light could not be fully excluded.

Home areas were configured fairly similarly, consisting of an entry zone into each home area. The entry zones specifically on the ground floor leading to Spruce Court and Chestnut Hill home areas each had a small sitting area across from an elevator. These zones were equipped with pot lights for illumination. The areas were quite dark with the pot lights illuminating small focused sections. The general lux ranged from 50 to 150, depending on whether the meter was directly under the pot light or in between the pot lights. The general requirement was a minimum level of 215.28 lux spread out evenly throughout.

Other dark areas were noted where pot lights were the only source of illumination. This included the Evergreen Lane home area in the corridor near the utility rooms and the corridor outside of the activity office (#1205). The licensee would need to have these sections and other similar areas measured at night in order to establish accurate illumination levels without interference of natural light to determine compliance with s. 18 of the Regulation. [s. 18.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Resident #004's plan of care identified that they displayed responsive behaviours. Interview with registered staff #140 and PSW #141 both stated that they did exhibit responsive behaviours and interventions included but were not limited to, encourage the resident to watch television, speak calmly and re-approach. Interview with registered staff #114 stated that the resident did exhibit responsive behaviours and confirmed that the written plan of care did not include their interventions and resident #004's responses to the interventions were not documented. [s. 53. (4) (c)]

WN #10: 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 failed to ensure that planned menu items were offered and available at each meal and snack.

Resident #002's plan of care identified they were at high nutrition risk and followed an individualized menu, as confirmed by the Registered Dietitian (RD).

On July 22, 2016, at 0915 hours, resident #002 was provided breakfast that did not include fruit. Interview with dietary staff #109 reported fruit was on the menu for residents; however, fruit was not served to resident #002. Review of the dietary kardex in the servery directed staff to not serve the resident the fruit on the menu and to refer to their individualized menu. Review of the resident's individualized menu listed a different fruit was to be served that day. Dietary staff #109 confirmed that the other fruit was available in the servery. After it was identified during the interview with the Long-Term Care Home's Inspector, dietary staff #109 did not offer the item to the resident. The resident reported they enjoyed that fruit. The NSS confirmed staff should have offered the other fruit to the resident as part of their individualized plan menu. [s. 71. (4)]

Issued on this 7th day of September, 2016

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

Original report signed by the inspector.