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
Jun 10, 2013	2013_188168_0016	H-000212-13	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

LISA VINK (168), ASHA SEHGAL (159), BERNADETTE SUSNIK (120), CAROL POLCZ (156), DEBORA SAVILLE (192), LALEH NEWELL (147), SHARLEE MCNALLY (141), TAMMY SZYMANOWSKI (165), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 22, 23, 24, 25, 26, 29 and 30, May 1, 2, 3, 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, and 24, 2013.

Complaint and/or Critical Incident inspections were conducted concurrently with this inspection including: H-000245-13, H-000250-13, H-000158-13, H-00063-13, H-000092-13, H-000207-13 and H-000119-13. Findings of non-compliance from some of these concurrent inspections are contained in this inspection report.

During the course of the inspection, the inspector(s) spoke with the President,the Director of Nursing (DON), Assistant Directors of Nursing (ADON), Resident Care Coordinators (RCC), the Social Worker, Recreation Supervisor, recreational aide, scheduling clerk, physiotherapist, physiotherapist aides, the Medical Director, the Director of Performance/Quality/IT Systems, Executive Secretary, Nursing Assistant, Finance Clerk, Accountant, Food Service Manager (FSM), Food Service Supervisors (FSS), Manager of Engineering and Maintenance, Dietitians (RD), Housekeeping/Laundry/Security Supervisor, Admissions Co-ordinator, Infection Control lead, Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW), other unregulated staff, 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 - 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
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

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. 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 for resident #1001 indicated that staff were to "minimize environmental barriers" and "orientate to furniture/objects in key areas". During interview regarding the resident's falls, it was identified that the wheelchair was to be kept out of the residents sight to prevent self transfer and that the position of the bed may have contributed to the falls. In 2013, the resident sustained two unwitnessed falls, one of which resulted in injury. Staff suspected that the falls occurred as a result of the resident attempting to self transfer. The plan of care created November 2011, and in effect at the time of the falls, did not provide clear direction regarding fall prevention interventions.
B) Resident #4000 had a physician's order for a tilt wheelchair and no other safety devices. The plan identified the use of the tilt chair, however the Care Summary Sheet, in the flow sheet binder on April 29, 2013, included a hand written revision which indicated that the resident used a seat belt. The plan of care did not give clear directions to staff providing care regarding safety devices to be used.
C) The plan of care for resident #9925, identified the requirement for total assistance with toileting related to bowel and bladder incontinence. The plan did not indicate that the resident was known to toilet independently however was unable to report bowel functioning. Interview with staff, progress notes and the Bladder Function and Bowel Movement Chart identified knowledge of this behaviour and for this reason the bowel protocol was not consistently followed. The plan of care did not provide clear direction for staff regarding the residents toileting/continence status.
D) The Active Care Plan Report for resident #4007 identified interventions under risk of falls and transferring as one staff to transfer, however the plan related to therapy falls and balance noted two staff to assist with transfers. The Health Care Record Display indicated that the resident required one staff to assist with transfers, however the Care Summary Report identified two staff for transfers. The Care Summary Report noted that the resident did not have an indwelling catheter however the Active Care plan Report included a catheter due to urinary retention. The plan did not give clear direction regarding transferring or urinary status.
E) The diet notes for resident #3007 stated modified diabetic, no added sugar, two grams sodium restriction diet. The resident confirmed that they order off of the regular menu and did not receive anything special. The current diet order on the Medication Administration Record (MAR), the plan of care and latest dietary assessment indicated a modified diabetic, regular diet with no mention of any sodium restriction.

F) The diet notes for resident #3009 and RD's nutritional assessment of April 18, 2013, indicated small portions. The requirement for small portions was not included on the resident's Active Care Plan.
G) The diet notes for resident #3010 indicated a scoop of protein powder at meals. This was not found on the resident's Active Care Plan Report or last nutritional assessment dated April 11, 2013. The plan did not give clear direction regarding nutritional care needs. [s. 6. (1) (c)]

2. 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.

Resident #9925 had a Minimum Data Set (MDS) assessment dated as February 26, 2013. This assessment indicated that the resident had a reduction in the number of responsive behaviours demonstrated, the frequency of behaviours and an improvement in mood since the past quarter, which was consistent with the assessment completed November 28, 2012. The Resident Assessment Protocol (RAP) completed on March 1, 2013, identified that the clinical assessment, had not changed since the past quarter, which was inconsistent with the MDS assessment completed for the same period. [s. 6. (4) (a)]

3. Not all Substitute Decision Makers (SDM) had been given the opportunity to participate fully in the development and implementation of the plan of care.

A) Interview with the SDM of resident #6001 indicated they were not aware of the plan of care or interventions in place related to recommendations by the Behavioural Support PSW. The resident's room included pictures and signs to direct the resident. The SDM questioned who had placed the signage in the room. The SDM was unaware why the signage was hung and expressed concerns about the appropriateness and effectiveness. The Behavioural Support PSW confirmed that not all Behavioural Support staff involve SDM's in the development of the plan of care specifically related to interventions implemented.
B) Resident #6001 was started on medication on February 27, 2013. Documentation in the progress notes indicated a discussion was held with the resident's SDM regarding the medication change. Documentation on March 8, 2013, indicated the SDM received a phone call about medication changes, however was not aware of what the changes were.

C) Interview with the SDM for resident #6001 identified they were not aware of the changes to the resident's medication. The SDM expressed concerns and no consent was provided to initiate the medication. Changes were made to the medication on March 31, 2013, and the SDM was not informed until April 2, 2013. The SDM was not provided an opportunity to consent to initiation of medications. [s. 6. (5)]

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

A) Resident #4007 had an order to discontinue foley catheter in one week and then complete in and out catheterizations every six hours, as needed for volume over 400 milliliters (ml), and to use the bladder scan if needed. The resident had the catheter removed as ordered and one bladder scan was completed on that date which identified that the resident was retaining urine. Staff did not fully assess the resident over a six day period, when the resident returned to the hospital and was re-catheterized. The home maintained output records until the day following the removal of the catheter, however did not complete bladder scans to determine the volume of urine in the resident's bladder post urination and as a result were unaware if the resident required in and out catheterizations. Nursing staff interviewed confirmed that the home did have a bladder scanner and that this would be a method for staff to accurately assess the volume of residual urine in an individuals bladder.
B) The plan of care for resident #0986 indicated a dislike of apple juice and milk to drink. On May 14, 2013, the resident received a glass of apple juice and milk for the lunch meal and did not drink either beverage.
C) The plan, order and current diet list for resident #5000 indicated to provide a minced texture diet however; they received regular texture salad for the lunch meal May 15, 2013. Staff confirmed the resident received the regular texture and stated the minced texture was related to chewing difficulties however; the resident was currently able to tolerate a regular texture. The plan indicated the resident was to receive one tablespoon of cheddar cheese with their salad however, this was not provided for the lunch meal May 15, 2013, as staff reported it was not available.
D) The plan for resident #5000 included the treatment of hypoglycemia directions, dated July 11, 2011, which directed nursing to provide 10-15 grams of carbohydrate if the Capillary Blood Sugar (CBG) was less than four millimole/litre (mmol/l). The plan indicated that staff were to wait 15-20 minutes and then re-test the resident's blood sugar. If the results were less then four mmol/l than staff were to repeat the treatment however; if the results were greater than four mmol/l, staff were to provide the resident

a meal (if within the hour) or a snack from the list of items indicated on the plan. Registered staff confirmed that if interventions were taken, documentation of this action would be in the resident's progress notes. The resident experienced blood sugars below four mmol/l on eight occasions in 2013. Progress notes confirmed that the resident was not provided with interventions or follow up as directed in the plan.
E) The plan for resident #5001 indicated that the home was to provide consistent caregivers and all staff were to review care instructions before entering the room if they were unfamiliar with the resident's care. Staff interviewed confirmed that at least two of the three staff working days on March 25, 2013, were unfamiliar with the resident's care and routines. The resident and one staff member confirmed that the staff did not review the resident's care routines prior to initiating morning care. On March 25, 2013, registered staff entered the resident's room at 0700-0715 hours. The individualized routine indicated the resident did not wake up until later in the morning. The day staff confirmed that they were unable to understand and communicate with the resident when they provided morning care, that they were aware of a system in place to communicate with the resident but, were unable to state how to use the system, as detailed in the plan of care.
F) The plan for resident #0015 indicated they were to be provided with one scoop of beneprotein protein powder with 250 ml milk at each meal. During the lunch hour on April 29, 2013, the resident was found to be in their room. Staff interviewed in the dining room, indicated that the resident would be served a tray. The tray was prepared and contained a regular texture salad plate, soup, dessert, a cup of orange juice and a cup of milk. Staff indicated that the milk did not have anything in it just before it was to be delivered to the resident. The inspector intervened and the registered staff then proceeded to add the protein powder to the milk.
G) The plan for resident #3006 indicated a diet with a food group restriction. The resident was provided with the restricted food during the lunch meal on May 8, 2013.
H) The plan for resident #6003 indicated they were to be provided with double portions at each meal. During the lunch meal on May 13, 2013, the resident was provided with regular portions.
I) The plan for resident #6006 indicated they were not to have added salt or any juice except tomato juice. During the lunch meal on May 13, 2013, the resident was observed using the salt shaker at the table. On May 7, 2013, at the noon meal the resident was provided with orange juice.
J) The plan for resident #3004 indicated they were to receive an assistive feeding device, a scoop plate. During the lunch meal on May 13, 2013, a regular plate was provided.

K) The plans for residents #3003 and #3004 indicated that they were to receive small portions. During the lunch meal on May 13, 2013, the residents were provided with regular portions.
L) The plan for resident #3002 indicated they were to receive a small portion on a small plate as not to overwhelm the resident. During the lunch meal on May 13, 2013, the resident received a regular portion on a regular plate.
M) The plan for resident #3001 indicated they were to receive water at all meals. During the lunch meal on May 13, 2013, no water was provided. The diet list and plan indicated no leafy green vegetables or salad. The resident was observed having a salad for lunch on May 7, 2013.
N) The diet notes and plan for resident #3012 noted they were to receive two, 250ml nectar thickened water at meals. On May 7, 2013, during the lunch meal, the resident had two empty glasses in front of them throughout the meal and a mug of thin water. The resident confirmed they were not provided with thickened fluids or thickened soup, the resident indicated "I guess they forgot, I managed and good thing I didn't choke"
O) Resident #3013 was noted on the diet notes and the plan to be provided with half of both choices at lunch and supper. The resident was provided with one choice at lunch on May 7, 2013.
P) On May 7, 2013, resident #3014 was noted on the diet notes and plan to be provided with a low fat, high fibre diet. The resident indicated they were unsure what to have, as they had a menu but lost it. When staff was asked what was provided for low fat, high fibre diets, she thought the inspector was referring to protein. She reported that flax was only provided at breakfast. Upon further questioning, it was confirmed that the resident did have a menu, however, it was not located in the servery. The staff indicated that there was a fruit plate for the resident in the fridge, if they wanted it, however it was not offered to the resident. The diet notes indicated that the resident was to receive two water at all meals which was not provided. The resident reported they do not receive water.
Q) The plan for resident #2001 identified a pain assessment was to be completed every Tuesday on day shift. During the month of April 2013, a pain assessment was to be completed five times, however it was completed only three times. The resident was receiving a narcotic pain medication regularly and verbalized pain on several occasions. Staff confirmed the assessments were not completed. [s. 6. (7)]

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

Staff providing care to resident #6001 identified they do have access to the electronic plan however were unable to log onto the computer, as passwords had expired. One staff member who was able to access the computer was unable to navigate the program to find the plan of care for any residents in the home area. The plan and interventions related to responsive behaviours was located in the electronic documentation and front line PSW's were unable to access the information. [s. 6. (8)]

6. Not all residents were reassessed and the plan of care reviewed and revised with change in the care needs.

A) Resident #2001 experienced a change in care needs and the care was not reassessed or revised. A urine specimen report was received at the home in 2013, indicating a urinary tract infection. The report was not reviewed by the physician and the resident did not receive a change in the care. The resident was transferred to the hospital six days later, with sepsis, which was confirmed with the physician and nursing staff.
B) The plan for resident #2001 was not updated to reflect the changes in needs after returning from hospital. The resident was admitted to the hospital. The resident returned to the home four days later. The plan was not updated to reflect the changes in health status. The plan of care by the dietary and nursing departments, completed on return from hospital, was not revised to include all current needs of the resident.
C) Resident #9863 was not reassessed related to pain when the care needs changed. The resident had a fall in 2013 and sustained a fracture. The resident complained of pain, from the injury, the following day, and received increased narcotic medication 21 times over a 16 day period. The resident reported continued pain in the area when touched, with exacerbation when positioned in a specific location. Staff confirmed the resident continued to complain of pain and it was now considered chronic. The weekly assessments, identified pain in the specific location but the plan was not revised. The pain plan identified the cause related to arthritis and an old fracture and did not identify the new fracture or include strategies to prevent pain in the specific location.
D) The current care plan for resident #0015 indicated that staff were to apply a specific dressing as ordered. Progress notes of March 12, 2013, indicated that the physician had changed the dressing to another dressing. The plan indicated that the resident had a stage II ulcer, secondary to incontinence and a stage IV pressure ulcer with a diagnosis. Registered staff confirmed on April 29, 2013, that the stage II ulcer

was resolved and that the plan was not revised with changes in the residents skin care status.
E) Progress notes from November 2012, indicated that resident #0986 had poor oral intake with refusals to eat. The food and fluid intake form for November 2012, indicated the resident only consumed five breakfast meals for the entire month and refused or had no intake for at least 36 meals that month. Nursing initiated a referral for poor fluid intake on Nov 12 and Nov 20, 2012, as the resident had consumed five glasses or less of fluid 19 days in a row (November 6 until 25, 2012). The RD confirmed that not all referrals received related to hydration were completed and there was no reassessment completed related to these referrals. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 Substitute Decision Makers (SDM) have been given the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. Not all restrained residents were done so by the use of a physical device, other than in accordance with section 31 of the Act.

A) Resident #4000 was observed on April 29, 2013, to be in a wheelchair using a front fastening seat belt. The resident was not able to remove the belt on request and staff interviewed confirmed that the resident was not able to open the device. According to the clinical record the use of the belt was done so without an order, consent or monitoring records in place. This information was confirmed during staff interview.
B) Resident #4003 was observed to be wearing a front fastening clip style seat belt on April 29, 2013. The resident was unable to release the device on request and the RPN interviewed reported that she did not believe the resident was able to remove the device on demand. The resident did not have a current order in place for the use of the device. The resident's order for a clip belt was discontinued on February 6, 2013, when a tilt chair was ordered as a Personal Assistance Service Device (PASD). The RPN confirmed that the resident did not have an order in place for the use of the device, which was being used.
C) Resident #0883 was not repositioned at least once every two hours when being restrained by a physical device. The resident was up in the wheelchair and a lap belt applied at 1130 hours, on April 30, 2013. The resident returned to the lounge at 1235 hours and was observed until 1409 hours. The belt was not released nor did staff reposition the resident during this time. Staff confirmed that the resident was last positioned at 1130 hours. The resident was observed up in the wheelchair with a lap belt applied on May 3, 2013, at 1020 hours until 1145 hours. The belt was not released and staff did not reposition the resident during this time. Staff confirmed that the resident was last positioned at 0915-0930 hours after morning care was provided.
D) Resident #4003 was observed on April 29, 2013, at 1050 hours, to be wearing a front closing clip style seat belt which was loosely applied around the abdomen. The belt was applied loosely allowing staff to easily insert one hand width between the resident's abdomen and the belt. The RPN interviewed confirmed that the belt was applied loosely and tightened the belt before contacting therapy services to review the application of the device.
E) On May 1, 2013, resident #0883 had a seat belt applied that was five inches from their pelvic crest. Three staff interviewed were unable to identify that the belt was applied loosely nor were they able to provide information on how tight or loose the belt should be applied. The DON confirmed that restraint education was completed August 13, 2012, and included direction for staff to apply seat belts with just enough

space for two fingers to fit between the belt and the resident's pelvic crest. The staff interviewed did not complete the education and manufacturer's instructions were not available when requested.
F) On May 14, 2013, at 1444 hours, resident #5005 had a loose seat belt applied five inches from the pelvic crest. Registered staff confirmed that the belt was loose and tightened the belt on request of the inspector. Staff confirmed that the belt was a restraint. [s. 30. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. Not every resident, at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Resident #0883 returned from hospital in 2012. There was no head to toe assessment completed when the resident returned from hospital. Registered staff confirmed that a progress note on return from hospital, identified bruising on the resident's arms however, it was confirmed a full head to toe assessment was not completed by registered staff. [s. 50. (2) (a)]

2. Not all residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) The Bath Day Skin Assessment, completed by a PSW, identified that resident #9925, had an intact water blister on the back of the right thigh on January 3, 2013. The progress notes identified a new area of altered skin integrity on January 5, 2013, a water blister, on the right thigh, which was treated. Discussion with the RPN identified that registered staff would sign the Bath Day Assessment when PSW staff brought it to their attention with any concerns. This tool was not signed by registered staff January 3, 2013. The area of altered integrity was not assessed or documented by a registered nursing staff until January 5, 2013.
B) Resident #9709 did not have an assessment of pressure ulcers using a clinically appropriate assessment instrument. On March 10, 2013, the resident was identified as having open skin on areas, that had previously healed. The registered staff identified the skin breakdown were stage II pressure ulcers as a result of sitting and incontinence. The documented assessment in the progress notes for the areas of altered skin were not completed until March 13, 2013. The last Bates-Jensen assessment was completed December 31, 2012, which was prior to March 2013, and did not include an assessment of the current open areas.
C) Progress note for resident #4006, noted that a PSW reported an open area, the size of a quarter, and the area was noted by the same staff last week. A request was made that day staff assess and treat the area, as appropriate. Interview with the PSW, who reported the area, identified that the skin breakdown was reported to a RPN, when first identified. Interview with the RN confirmed that the PSW, indicated that she previously reported the skin breakdown a RPN and that the area was not in the record. The RN also confirmed that the PSW reported that the area was now larger

than when initially noted (staff acknowledged there was a documentation error in the progress note, when reviewed on the request on the inspector). There was no documented assessment of the area of altered skin integrity, by a member of the registered nursing staff at the home, for at least eight days after the area was identified, when the resident was available for assessment. [s. 50. (2) (b) (i)]

3. Not all residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #9925 was assessed and treated on January 5, 2013, for a large water blister on the right thigh. The Treatment Administration Record (TAR) identified this area was resolved on January 21, 2013, however there was no reassessment of the area of altered skin integrity from January 5 until 21, 2013. It was noted that the resident had subsequent altered skin integrity in this area identified in March, April and May 2013, which is currently resolved. The RPN confirmed that all assessments related to skin and wound care would be recorded electronically and should be completed on a weekly basis.
B) Resident #9709 had stage II pressure ulcers identified on March 10, 2013. The resident and nursing staff confirmed the stage II pressure ulcers were present as of May 7, 2013. The progress notes reviewed noted documented skin assessments on March 13, 27 and April 10, 2013. Review of assessments completed from December 2012 until May 2013, identified the last Bates-Jensen Wound Assessment was completed on December 31, 2012. Assessments were not conducted on a weekly basis by registered staff.
C) Resident #0015 had a wound identified on September 29, 2012. Skin integrity was not assessed on a weekly basis by the registered nursing staff, from September 29, 2012, until April 30, 2013, the wound was not assessed by the registered staff on 16 out of 30 weeks. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

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 :