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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 23, 2017	2017_543561_0016	024709-17	Resident Quality Inspection

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET TORONTO ON M3H 5S9

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

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

DARIA TRZOS (561), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30, 31, 2017 and November 1, 2, 2017.

A Follow Up Inspection was completed during this RQI with the log number 018870-17 related to plan of care relating to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistance Director of Care (ADOC), Social Worker, Programs and Support Services Manager, Registered Dietitian, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Family Council Representative, Resident Council President, families and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed documents that included but were not limited to: resident clinical health records, policies and procedures, training records, assessment tools, and program evaluations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2017_547591_0009	583

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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan was implemented.

The annual Minimum Data Set (MDS) assessment on an identified date in 2017, indicated that resident #006 was occasionally incontinent of bladder and continent of bowels.
The MDS on the next quarterly assessment, indicated that the resident deteriorated and was coded as being frequently incontinent of bladder and usually continent of bowels.

The Bladder Continence Assessment completed at the time of change, indicated that resident had a change in incontinence from occasional to frequent and now required two person extensive assistance with toileting.

The written plan of care was reviewed after the change and indicated that "resident required one staff to provide extensive assistance with transferring on/off toilet for safety".

Interviewed PSW #109 who provided direct care to the resident and indicated that the resident was now frequently incontinent of bladder and required one person assistance with toileting.
Interviewed RN #101 and indicated that resident had a change in incontinence and was assessed based on that change. RN confirmed that the resident required one person assistance; however, the assessment indicated that resident required two person assistance.
RN #101 stated that the process in the home was that once the coding was done in MDS, staff observed residents for patterns for three days and then they complete the assessment based on that information. The care plan was then revised based on the assessment.

The ADOC was interviewed and indicated that when there was a change in continence, staff were expected to complete a three day observation of the resident and complete the continence assessment in PCC and update the care plan.

The licensee failed to ensure that resident #006 who was incontinent had an individualized plan of care to manage bladder incontinence based on the assessment. [s. 51. (2) (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 resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan is implemented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During a medication pass observation at lunch time on an identified day, LTCH Inspector observed resident #024 was not positioned well during their meal while they were fed and some of the food was spilling from their mouth. RPN #100 indicated that this was how they fed the resident because resident was not able to sit upright.

The written plan of care was reviewed and did not identify specific techniques to assist the resident and did not include any strategies or interventions to assist resident with better positioning during meals.

Interviewed the RD and indicated that they were aware of the resident's positioning and that they could try different strategies to ensure better better positioning. RD confirmed that the plan of care did not identify interventions for better positioning during meals to promote safe eating.

The licensee failed to ensure that the home had a dining service that included proper techniques to assist resident #024 with eating, including safe positioning of this resident. [s. 73. (1) 10.]

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 home has a dining and snack service that includes proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) Resident #016 indicated during the interview that they would like to take a bath sometimes; however they only received a shower.
PSW #107 was interviewed and indicated that resident #016 preferred to have showers.
The preference for either a bath or shower was written in the written plan of care.
RPN #106 was interviewed and indicated that resident preferred showers.
The clinical records were reviewed during inspection. The admission note in PCC, indicated that resident preferred either showers or baths.
The written plan of care was reviewed and did not have a preference included for either a bath or shower.
The RPN #106 confirmed that the written plan of care did not included the resident's preference for a shower and it was an expectation that it would have.

B) Resident #007 was interviewed during this inspection and stated that they preferred to have a shower. The clinical records were reviewed and the admission note did not indicate the resident's preference for shower or bath. The written plan of care was reviewed and did not identify resident's preference for shower or bath.

The licensee failed to ensure that the written plan of care set out the planned care for residents #007 and #016 related to bathing. [s. 6. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the record of the care conference date, participants and the results of the conference was kept in the home.

Resident #016 reported to LTCH Inspector that they believed the home did not invite them to the care conference; however, this could not be confirmed by LTCH Inspector during inspection. The Social Worker was interviewed and confirmed that the care planning conference was held six weeks after resident's admission. They also confirmed that resident was invited and attended the meeting.
The clinical records were reviewed by the LTCH Inspector and the documentation of the care conference could not be found in the electronic record or the chart. Social Worker indicated that they could not find the documentation of the care conference and that it was an expectation that a record was kept in resident's clinical record.

The policy titled, "Care Conference", policy number LTC-CA-WQ-100-02-12, revised May 2016, indicated that "care conference are held 6 weeks after admission and then annually, care conference include the resident, the SDM, and representatives from the interdisciplinary care team. Documentation related to the resident care conference will be found in the resident health record".

The licensee failed to ensure that the record was kept of the care conference held for resident #016 in January 2017. [s. 27. (1) (c)]

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who is a member of the staff of the home.

Resident #007 was admitted to the home on an identified date in 2017 and internally acquired altered skin integrity after admission. Resident's clinical records were reviewed and revealed that the referral was not sent to the Registered Dietitian (RD) when the resident first acquired the altered skin integrity. RPN #106 was interviewed and confirmed that the resident was not referred to RD and this was an expectation in the home.
RD was interviewed on November 1, 2017 and indicated that they did not receive the referral to assess resident after the altered skin integrity was noted. The RD confirmed that they were not aware of the resident's wound.

The licensee failed to ensure that resident #007 was assessed by RD when they were noted to have altered skin integrity. [s. 50. (2) (b) (iii)]

Issued on this 11th day of December, 2017

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

Original report signed by the inspector.