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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2016	2015_215123_0020	033078-15	Resident Quality Inspection

Licensee/Titulaire de permis

CLARION NURSING HOMES LIMITED
337 HIGHWAY #8 STONEY CREEK ON L8G 1E7

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

CLARION NURSING HOME
337 HIGHWAY #8 STONEY CREEK ON L8G 1E7

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

MELODY GRAY (123), CAROL POLCZ (156), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 30, December 1, 2, 3 & 4, 2015.

During the course of the inspection, the inspector(s) spoke with Residents, family members, PSWs, registered staff, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument-Minimum Data Set Coordinator (RAI-MDS Coordinator) and the Environmental Services Manager (ESM).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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. 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 has failed to ensure that when bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices to minimize risk to the resident.

A) Resident #018 was observed in bed with two quarter rails in use on December 1, 2015. Interview with the Director of Care(DOC) and the Assistant Director of Care (ADOC) and a review of the written plan of care confirmed the resident used two quarter rails while in bed for positioning. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the DOC and the ADOC on December 2, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place.

B) Resident #031 was observed in bed with two quarter rails in use on December 2, 2015. Interview with a Personal Support Worker (PSW) #103 and review of the written plan of care confirmed the resident used two quarter rails while in bed for repositioning. A review of the resident's written plan of care did not include an assessment of the bed rails being used. Interview with the DOC and ADOC on December 2, 2015, confirmed that the home did not have a formalized assessment for the use of bed rails in place. [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,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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. (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 the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident as evidenced

by:

The record of identified resident #011 was reviewed and the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment indicated that they had an increase in physically abusive behaviors according to their 90-day assessment relative to their admission assessment.
The RAI-MDS Coordinator was interviewed and confirmed that the resident's RAI-MDS assessments indicated that the resident had an increase in physically abusive behaviors as above.
The resident's plan of care were reviewed it did not include information related to physically abusive behaviors.
The DOC and ADOC were interviewed and they confirmed that the resident's plan of care did not include any information related to the resident's physically abusive behaviors. [s. 6. (2)]

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, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other as evidenced by:

The record of resident # 011 was reviewed and the RAI-MDS assessment noted that their locomotion (in room and adjacent corridor on the same floor) declined one level or more according to the 90-day assessment completed in July 2015 relative to the admission assessment which was completed in April 2015. In April 2015, the resident was noted to require supervision and set up help only for locomotion. In July 2015, the resident was noted as needing limited assistance and one-person physical assist with locomotion.

The resident's PT Health Physiotherapy Assessments dated April and July 2015 were reviewed and both were identical. There were no changes noted in the physiotherapy assessments indicating a change in the resident's locomotion.
The plans of care were reviewed and they indicated that the resident went from being independent with mobility to requiring assistance of staff due to decline in physical status.

The RAI-MDS Coordinator was interviewed and they confirmed that the information in the assessments was as noted above. The DOC and ADOC were interviewed and reported that the resident had a decline in their locomotion between April and July 2015. They

confirmed that the physiotherapy assessments and the RAI-MDS assessments were not consistent with and did not complement each other [s. 6. (4) (a)]

3. The licensee has failed to ensure that resident #014's plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

On December 2, 2015, a review of resident #013's plan of care indicated that when the resident was in bed the resident was to have two side rails up at all times. On December 1, 2015, the resident was observed in bed with no side rails up and the side rails were removed from the bed. Interview with registered staff #104 confirmed the resident did not have side rails on their bed, and they could not confirm when the side rails were removed. Registered staff #104 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
4. Vision. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for was based on, at minimum, interdisciplinary assessment of the following with respect to the resident: Communication abilities including hearing and language as evidenced by:

The RAI-MDS assessment for resident #010 and the RAP dated September 27, 2015, were reviewed and indicated that the resident had a communication impairment. A plan of care was not in place to address the resident's communication needs as indicated in the the RAP. The DOC confirmed that this information should be in the resident's plan of care. [s. 26. (3) 3.]

2. The Licensee failed to ensure that the plan of care was based on, at minimum, interdisciplinary assessment of the following with respect to the resident: Vision as evidenced by:

The RAI-MDS assessment for resident #010 and the RAP dated September 27, 2015, indicated that the resident had a visual impairment. A plan of care was not in place to address the resident's visual impairment as indicated in the RAP. The DOC confirmed that this information should be in the resident's plan of care.

B. The Licensee failed to ensure that the plan of care for resident #019 addressed their vision needs. The RAI-MDS assessment for resident #019 and the RAP dated September 27, 2015, indicated that the resident had a visual impairment. A plan of care was not in place to address the resident's visual impairment as indicated in the RAP. The DOC confirmed that this information should be in the resident's plan of care. [s. 26. (3) 4.]

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment as evidenced by:

It was noted during observation of resident #013 during stage one of the inspection, that the resident had a bruise on their left forearm. Documentation or assessment of the altered skin integrity was not found in the clinical record. Registered staff #100 reported that the bruise was of unknown origin and had been mentioned during report but could not recall when. Interview with registered staff #100 and #101 on December 2, 2015 confirmed that the resident with altered skin integrity should have been assessed by a member of the registered nursing staff and had not been. [s. 50. (2) (b) (i)]

WN #5: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee failed to ensure that, (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence as evidenced by:

The record of resident #011 was reviewed including the April and July 2015 RAI-MDS assessments. The record indicated that the resident had incontinent episodes once a week or less at admission and that they declined in bladder continence control according to the 90-day assessment relative to the admission assessment.
There was no documentation found in the resident's record that a continence assessment using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence was conducted at admission or when their continence status declined.
The RAI-MDS Coordinator was interviewed and confirmed the information as noted in the assessments.
The ADOC and DOC were interviewed and they confirmed that assessments of the resident's continence was not conducted using a clinically appropriate instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The licensee failed to ensure that, (a) each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for

assessment of incontinence as evidenced by:

The record of identified resident #017 was reviewed including the RAI-MDS assessments and it was noted that the resident was identified as being at low risk for incontinence and was frequently or fully incontinent of bowel or bladder according to the most recent assessment.

There was no documentation found in the resident's record that an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

The RAI-MDS Coordinator was interviewed and confirmed the accuracy of the assessment information.
The ADOC and DOC were interviewed and they confirmed that an assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not conducted. [s. 51. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs included body mass index and height upon admission and annually thereafter as evidenced by:

During stage one of the inspection on November 30, 2015, ten identified residents on the lower floor were noted not to have their heights taken and recorded on an annual basis. This was confirmed by the DOC and ADOC on December 3, 2015. [s. 68. (2) (e) (ii)]

Issued on this 22nd day of February, 2016

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

Original report signed by the inspector.