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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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
Apr 30, 2015	2015_334565_0007	T-1671-15	Resident Quality Inspection

Licensee/Titulaire de permis

CLURELEA LTD.
272 QUEEN STREET EAST BRAMPTON ON L6V 1B9

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

GOOD SAMARITAN NURSING HOME
481 Victoria Street East Alliston ON L9R 1J8

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

MATTHEW CHIU (565), ANN HENDERSON (559), BARBARA PARISOTTO (558)

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): April 1, 2, 7, 8, 9, 10, 13, 14, 2015.

The following Complaint Intake was inspected concurrently with this Resident Quality Inspection: T-1513-14.

During the course of the inspection, the inspector(s) spoke with the administrator, director of resident care (DRC), registered dietitian (RD), nutrition manager (NM), cook, environmental services manager (ESM), resident assessment instrument (RAI) coordinator, registered staff, personal support workers (PSWs), dietary aide (DA), residents and family members.

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

During the course of this inspection, Non-Compliances were issued.

7 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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months, a change of 10 per cent of body weight, or more, over 6 months.

A record review revealed a nutrition referral on an identified date was sent to the RD for resident #5 related to a weight change of more than 7.5 per cent over three months in early 2015. The referral indicated the resident was not receiving supplementation and not meeting fluid goals. Record review revealed the RD spoke with resident #5 to encourage the resident to eat more and the resident becomes full before the end of the meal. A nutritional assessment of the resident's nutritional requirements could not be located.

An interview with the RD confirmed the resident's nutritional requirements were not assessed when the resident experienced a 7.5 per cent change in body weight. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. A record review revealed two nutrition referrals for resident #9 were sent to the RD. The first referral, dated on an identified date, was related to an 8 per cent weight change over 90 days, decreased appetite and not meeting fluid intake. A second referral, dated about a month after, related to a 10 per cent weight change over 180 days, poor appetite, nauseated and not meeting fluid goal.

Record review revealed resident #9 had a weight change of 8 per cent over a three-month period prior to the first referral. The RD responded to the referral and initiated a nutritional supplement for an identified medical condition for the resident. A nutritional assessment of the resident's nutritional requirements could not be located.

A further review revealed resident #9 had an additional weight change in the following month. The RD responded to the second referral and increased the daily amount of the nutritional supplement for the same identified medical condition. A nutritional assessment of the resident's nutritional requirements could not be located.

An interview with the RD confirmed resident #9's nutritional requirements were not assessed when the resident experienced a 7.5 and 10 per cent change in body weight. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated: A change of 7.5 per cent of body weight, or more, over three months, a change of 10 per cent of body weight, or more, over 6 months, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

On an identified date, resident #31 was wheeled from an identified home area to the resident's room.

When the resident was wheeled down the hallway, it was observed the resident's adaptive pants had not been put on properly and the resident's thigh and continent

product were visible.

The resident requires total assistance to get dressed and two identified PSWs failed to ensure the resident was properly dressed before being returned to the resident's room.

An identified registered practical nurse (RPN) revealed he/she had previously reminded staff to ensure residents are properly dressed before leaving the identified home area. The RPN asked a second member of staff to assist in completing the task of dressing the resident and confirmed the resident had not been treated with respect. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident has the right to be cared for in a manner consistent with his or her needs.

On two identified dates, resident #4 was observed with an injury on an identified area of the resident's upper body.

Record review and staff interviews revealed on an identified date, during care, the resident's upper body struck the bed rail causing immediate injury.

An identified PSW revealed the resident was lying closer to the bed rail than normal and the PSW did not reposition and centre the resident before providing care. The PSW stated he/she normally lowers the side rail but on this occasion the PSW did not and as a result resident #4's upper body struck the side rail when rolled over.

The resident has identified medical conditions and is totally dependent on the PSW to receive care consistent with the resident's needs.

An incident report was completed and the resident was seen by the Doctor who confirmed there was an injury. The administrator confirmed an investigation had taken place and on this occasion the resident had not been cared for in a manner consistent with his/her needs. [s. 3. (1) 4.]

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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

A review of the plan of care for resident #5 indicated the following information related to the resident's diet order:

- physician's order review indicated the diet as regular diet, minced meat,
- the diet list located in the dining servery indicated the diet as regular diet, minced texture and
- the care plan indicated the diet as regular diet, minced meat texture.

An interview with an identified PSW revealed resident #5 receives a regular diet, minced texture and an identified RPN revealed the resident receives a regular diet, minced meat texture.

An interview with the RD revealed the correct diet order for resident #5 is regular diet, minced meat texture and confirmed the directions set out in the plan of care for resident #5 are unclear. [s. 6. (1) (c)]

2. Record review of resident #8's plan of care indicated the resident should be reminded to walk with his/her walker at all times. When walking in the resident's room, the resident requires one-person extensive assistance. When walking in corridor, the resident is independent with no set-up assistance required.

Interviews with two identified PSWs and an identified registered staff revealed the resident walks independently with a walker both in the resident's room and in the corridor, and sometimes staff needs to remind the resident to use his/her walker.

The staff members confirmed the directions set out in plan of care when the resident is walking in his/her room are unclear. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #5 fell in his/her room on an identified date. A review of resident #5's plan of care indicated the resident is at high risk for falls and staff should apply a chair alarm to the chair in the resident's room and ensure a call bell is within reach by the resident at all times.

A review of resident #5's post fall screen for resident/environmental factors form revealed the resident was unable to reach the call bell.

Interviews with two identified PSWs indicated on the identified date, resident #5 was assisted to sit on a chair in his/her room after taking a bath. The PSWs confirmed no call bell was placed in reach by the resident and the chair alarm was not applied to the resident's chair. The resident got out of the chair and fell. [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's equipment is kept clean and sanitary.

Observations made on two identified dates revealed resident #4's wheelchair arm rests and seat cushion were unclean.

An interview with a PSW after the second observation revealed the resident spits when being fed resulting in an unclean chair. The PSW stated the chair should be wiped clean as required.

On the next day, the inspector again observed the arm rest and seat cushion of resident #4's wheelchair to be unclean.

A record review indicated the wheelchair was cleaned on the day after the third observation, as per the weekly cleaning schedule.

In the next week, the inspector observed the arm rest and seat cushion of resident #4's wheelchair to be unclean.

The DRC confirmed resident #4's wheelchair was unclean and stated the home's expectation is the resident's wheelchair would be wiped down by the PSW as needed between weekly scheduled cleaning. [s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

Record review of the Residents' Council meeting minutes on an identified date revealed the Council had raised a concern about meals not being served hot enough.

Record review and interview with the administrator indicated a written response was given to the Council assistant seven days after and the assistant would not take it to the Council until the next Council meeting in a month after.

Interview with the Residents' Council confirmed that the home did not respond to the Council in writing within 10 days after receiving the Residents' Council advice related to the concern. [s. 57. (2)]

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 has failed to ensure that the policies and procedures relating to nutrition care are implemented.

A review of the policy Registered Dietitian Documentation, revised on February 2011, indicates the following:
1. The RD after receiving a nutritional referral form, will assess the indicated resident in regards to the concern that has been indicated.
2. The RD will then assess the resident and fill out a resident nutritional assessment form indicating the type of assessment being done and the nutritional concerns and any interventions being implemented.

An interview with the RD revealed when a referral form is received, an assessment is completed, an intervention or action is implemented and it is documented in the progress notes, communication book in the kitchen and on the referral form. The RD stated the resident nutritional assessment form is used at admission for the initial nutrition assessment.

The RD confirmed the resident nutritional assessment form is not being completed as per the Registered Dietitian Documentation policy and procedure. [s. 68. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu items are prepared according to the planned menu.

On an identified date during a dinning observation in an identified home area, the inspector observed an identified staff member serving one half portion of boiled egg to residents #41, #42 and #43. The show plate identified the portion for boiled egg to be two halves.

A review of the diet spreadsheet revealed residents receiving a regular, modified diabetic or reducing diet, regular texture, should receive a portion of four halves of boiled egg.

A review of the diets revealed resident #41 receives a regular diet, and #42 and #43 receive a reducing diet.

An interview with the identified staff member revealed the portion of boiled eggs served to the residents was indicated on the show plate as two halves. An interview with another identified staff member revealed the portions of menu items are indicated on the production sheets and the production sheets indicated the portion of the boiled eggs was two whole eggs or four halves.

An interview with the FSM confirmed the portion of the boiled eggs was four halves and the residents should have received four halves. [s. 72. (2) (d)]

Issued on this 15th day of May, 2015

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

Original report signed by the inspector.