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
Oct 26, 2018	2018_520622_0027	011961-18, 026848-18	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Kentwood Park
2 Ontario Street PICTON ON K0K 2T0

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

HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 9, 10, 2018.

Log #011961-18 and Log #026848-18 related to complaints of staffing levels and resident care and services and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), the Head Cook, Personal Support Workers (PSW), a Health Care Aide (HCA) a Nurses aide (NA), residents and families.

Also during the inspection, the inspector reviewed health records, the licensee's staffing plan, the quarterly quality report, call in procedure, call in lists, PSW schedules, the licensee's policies specific to Food and Fluid Intake # NC-1.8, Complaints procedure #AM - 6.1, observed resident to resident interaction and resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 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 has failed to ensure that the home is equipped with a resident-staff communication and response system that can be accessed and used by resident #001 at all times.

Resident #001 uses a wheelchair to mobilize throughout the nursing home and sits in their room at the bedside.

During the inspection, inspector #622 made observations on four separate occasions of resident #001's call bell placement; October 2, 2018 at 1028, 1235 and 1540 hours and October 3, 2018 at 0915 hours. During each of these observations resident #001's call bell was tied on the bed rail on the opposite side of the bed against the wall covered with the bedspread. On three of the four observations resident #001 was sitting in their wheelchair at their bed side and on October 3, 2018 at 0915 hours, resident #001 stated that they could not reach their call bell.

On October 2, 2018 inspector #622 notified RN #102 of the concern related to resident #001's call bell being out of their reach. RN #102 stated they would notify staff of the concern and take care of it.

During an interview on October 3, 2018 at approximately 1130 hours, Director of Care (DOC) #100 along with inspector #622 observed the placement of resident #001's call bell at their bedside. The call bell continued to be tied on the bed rail on the opposite side of the bed against the wall covered with the bedspread. DOC #100 stated that the resident would not be able to reach the call bell cord and furthermore, the call bell cord should have been untied from the bed rail and brought to the near side of the bed for resident #001's access. [s. 17. (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 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., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

As part of the Nutrition Care and Hydration Program, the licensee's policy and procedure #NC-1.8 related to Food and Fluid Intake indicated a food and fluid intake record shall be maintained. The nursing and personal care staff shall be responsible for monitoring and recording intake subsequent to each meal and nourishment pass.

A review of the Dietary flow-sheet for resident's #001, #002 and #003 on Mede-Care indicated that food and fluid intake at Dinner, afternoon and evening snacks on three specified dates had not been documented.

During separate interviews with inspector #622 on October 9, 2018, PSWs #103, #108, and #117 stated that on three specified dates, residents #001, #002 and #003 would have been offered their dinner, afternoon and evening snacks however the intake documentation had not been completed at the time.

During an interview on October 9, 2018 at 1445 hours, inspector #622 informed the Administrator that there was no documentation of dinner, afternoon and evening snacks intake for residents #001, #002 and #003 on three specified dates. The DOC stated that residents #001, #002 and #003 would have had their meals and snacks on the three specified dates however the documentation had not been completed. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of the hard copy bath schedule kept at the nurses station as well as documentation on Point of Care (POC) on the electronic health records indicated there was no documentation to support that the following residents received any baths from one day prior to two days after their scheduled baths as follows;
- on a specified date and shift – residents #001, #008, #010, #011, #012.
- on a specified date and shift – residents #004, #012, #013, #014.
- on a specified date and shift – residents #016, #017, #018, #019, #020, #021.

After a review of the shift to shift reports and the electronic records for each of the residents listed above, there was no documentation to support that the missed baths were made up at a previous or later time.

During an interview with inspector #622 on October 4, 2018 at approximately 1425 hours, PSW #108 stated they had worked on the first of the three specified dates and shifts. PSW #108 stated that due to working short PSW staff that shift, none of the baths were completed.

During an interview with inspector #622 on October 4, 2018 at approximately 1600 hours, PSW #103 stated they had worked on the second and third of the three specified dates. PSW #103 stated that there had been two showers completed on the second of the specified dates for residents #006 and #007. PSW #103 also stated they had not completed any baths during their shift on the third specified date however Nurse Aide (NA) #109 may have completed some on their shift.

During a telephone interview with inspector #622 on October 4, 2018 at 1658 hours, RN #110 who worked a specified shift on the second and third of the three specified dates stated they could not recall any baths being completed on the second of the specified dates. RN #110 further stated that NA #109 may have completed some baths on the third of the specified dates but could not recall any details.

During an interview with inspector #622 on October 5, 2018 at approximately 0958 hours, Nurse Aide (NA) #109 who worked during a specified shift on the second and third of the three specified dates stated they had completed one bath for resident #015 on third of the specified shifts. NA #109 further said they had not completed any other baths to make up the missed baths from the specified shifts when working on two of the three specified dates.

On October 5, 2018 at 1446 hours, inspector #622 interviewed PSW #107 who worked the specified shift on the third of the three specified dates. PSW #107 stated no baths were done that specified shift as they were short PSW staffing.

During an interview with inspector #622 on October 4, 2018 at approximately 1634 hours, RN #111 stated they had worked all three of the specified dates and shifts when the PSW staffing level was noted to be short. RN #111 stated, when the PSW staff level was short, staff are required to prioritize and quite often baths don't get done that shift, if possible the missed baths may be completed the next day. RN #111 further said that they have often heard residents say that they would have to wait until their next bath date before receiving their bath. RN #111 stated normally they would write any missed baths reported to them on the shift to shift report for another shift to complete however was not aware if any baths were missed during the three specified dates and shifts.

During an interview with inspector #622 on October 9, 2018 at approximately 1040 hours, DOC #101 said when PSW staffing levels are short, the staff try to get baths done during that shift or the next day, however it was possible baths may be missed. DOC #101 reviewed some of the residents on the bath list and cross referenced the documentation for the three specified dates when the PSW staffing level was short. DOC #101 noted documentation to be absent for baths. Inspector #622 informed DOC #101 that staff had stated that there had only been a total of three baths for residents #006, #007, #015 completed for the specified date and shifts when the PSW staffing level was short. DOC #101 stated that if the staff said the baths were not done, then they were not done. [s. 33. (1)]

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 that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition., to be implemented voluntarily.

Issued on this 26th day of October, 2018

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

Original report signed by the inspector.