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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2015	2014_198117_0030	O-000786-14	Complaint

Licensee/Titulaire de permis

458422 ONTARIO LIMITED
220 EMMA STREET CORNWALL ON K6J 5V8

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

SANDFIELD PLACE
220 EMMA STREET CORNWALL ON K6J 5V8

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

LYNE DUCHESNE (117), MEGAN MACPHAIL (551)

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): November 18 and 19, 2014.

The following complaint logs were completed in conjunction with this inspection: #O-0012034, #O-001181-14, #O-001172-14, #O-001246-14, #O-001057-14, #O-001035-14 and #O-000907-14.

During the course of the inspection, the inspector(s) spoke with several residents, several family members, several personal support workers (PSWs), several registered nursing staff (RN and RPNs), the food service supervisor, a physio therapy aide, the director of care (DOC) and the administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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. 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plans of care for several identified residents, are based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident. [Logs # O-000786-14 & #O-001035-14]

On November 19, 2014, the following was observed by Inspectors #117 and #551
• At 06:25 am, Resident # 5 was observed to be dressed in day clothes and sitting in the lounge. Resident #004 was observed to be dressed in day clothes and was being escorted down the hallway to the lounge by staff member S #110.
• At 06:20 am, Resident #10 was observed to be fully washed and dressed, lying in bed under the covers, sleeping, in his/her room.
• At 06:20 am, Resident #11 was observed to be fully dressed, awake and seated in his/her wheelchair, in his/her room.
• At 06:25 am Resident #12 was observed to be fully dressed, awake and seated in his/her wheelchair, in his/her room.
• At 06:25 am Resident #13 was observed to be fully dressed, partially awake and seated in his/her wheelchair in his/her room.
• At 06:37 am there were four residents dressed in day clothes in the lounge (Resident #8, Resident #9, Resident #4 and Resident #5).
• At 06:40 am Resident #1 was dressed in day clothes, including a green colored top and was sitting in his/her wheel chair beside his/her bed.
• At 6:40 am Resident #2 was dressed in day clothes, including a purple colored turtleneck sweater and was sleeping in bed under the covers.
• At 06:45 am care was being provided to Resident #3. At 06:55 am the resident was observed to be dressed in day clothes and sleeping under the covers.

Night staff member S#110 and day staff members S#107, S#108 and S#103 confirmed that Residents #11, #12, and #13 were washed, dressed and transferred to their wheelchairs at 5 am, except for Resident #10 who is still in bed, fully washed and dressed, as per home's night care sheet. At 06:25 am, PSW S#110 stated to Inspector #551 that the four residents #3, #4, #5 and #7 were listed for 6am care and that these residents had already received their morning care.

At the nursing station, the staff member S#103 showed Inspector #117 a two sheet document indicating that Residents #1, #7, #10, #11, #12 and #13 are to be given morning care at 5 am, 5 days per week and that Residents #2, #3, #4, and #5 are to be given morning care at 6 am, 4-5 days per week. Staff members S#103 and S#110 stated to Inspectors #117 and #551 that getting residents up at 5am/6am has been a long standing practice at the home implemented by the home's management. This practice is to facilitate the provision of morning care by both night and day shift staff to residents with greater needs (2 person assistance). The staff members S#103 and S#110 stated that they are unsure if the residents' substitute decision makers or families are aware of

this practice.

On November 19, 2014, a discussion was held with the home's Administrator and DOC related to the provision of early morning care to the above identified Residents. The DOC confirmed to Inspector #117 that the night time routines have been in place for a long period of time. The 5am/6am morning care routine list is supposed to be a guideline for staff. If the identified residents on the list are awake or are presenting with behavioural issues between 5am/6am, staff are to use their judgement and start providing am care to the identified residents. The DOC reported that Residents # 10 and #12 were always early risers and therefore the practice of providing care at 5 am was continued. Both the Administrator and DOC stated that this information would not be in the identified residents' individual plans of care and they were not aware if the identified residents' families were informed of the home's guidelines or if they gave their consent for their loved ones to be given care at 5 am.

A review of Resident #10's health care record was conducted by Inspector #117. Resident #10 has advanced cognitive impairments with limited ability to communicate. The resident requires 2- person assistance with all aspects of personal care, dressing and mobility. Progress notes of a specific day in August 2014, indicate that the resident had responsive behaviours at 04:50am. As Resident #10 was up beside his/her bed and presented with some agitation, documented nursing interventions were to give the resident his/her am care, washing, dressing and seating the resident in his/her wheelchair. As per documentation the resident did not present with any other behaviours after these interventions. No other information was found in Resident #10's chart or plan of care related to any night time or early morning responsive behaviours and the provision of personal care at 5 am or earlier as an intervention for responsive behaviours. There was no prior information in the chart indicating that it was the resident's sleep pattern or preference/habit to be up at 5 am, or that his/her SDM / family were aware of the resident being woken, washed, dressed and risen at 5 am and had given consent to this practice.

A review of Resident #11's plan of care was conducted by Inspector #117. Resident #11 has advanced cognitive impairments with aphasia. The resident requires 2- person assistance with all aspects of personal care, dressing and mobility. The resident is dependent on staff for all aspects of daily living. No information was found in the resident's chart or plan of care related to any personal care being done daily at 5 am. There was no prior information in the chart indicating that it was the resident's sleep pattern or preference/habit to be up at 5 am. There is no information in the chart related

to the resident having any behaviours during the night shift where the resident might benefit from being cared for early in the morning, or that his/her SDM / family were aware of the resident being woken, washed, dressed and risen at 5 am and had given consent to this practice.

A review of Resident #12's health care record was conducted by Inspector #117. Resident #12 has an advanced neurodegenerative disease with cognitive impairments and limited ability to communicate. The resident requires 2- person assistance with all aspects of personal care, dressing and mobility. The resident's current plan of care identifies that Resident #12 does have some responsive behaviours related to the presentation of physical aggression as a reaction to pain, constipation and ineffective coping related to the progression of the neurodegenerative disease. Reviewed progress notes do not identify any responsive behavioural issues in 2014. There is no information in the chart related to the resident having any behaviours during the night shift where the resident might benefit from being cared for early in the morning. Also, no information was found in the resident's chart or plan of care related to any personal care being done daily at 5 am. There was no prior information in the chart indicating that it was the resident's sleep pattern or preference/habit to be up at 5 am, or that his/her SDM / family were aware of the resident being woken, washed, dressed and risen at 5 am and had given consent to this practice.

A review of Resident #13's health care record was conducted by Inspector #117. Resident #13 has advanced cognitive impairments with limited ability to communicate. The resident requires 2- person assistance with all aspects of personal care, dressing and mobility. The resident's current plan of care identifies that Resident #13 does have some responsive behaviours related to verbal and physical aggression at sun downing. Reviewed progress notes do not identify any responsive behavioural issues in 2014 The only note related to the resident having some behaviours during night shift was on a specified day in November 2013 in which repositioning and provision of continence care addressed the resident's behaviours. There is no information in the chart related to the resident having any other behaviours during the night shift where the resident might benefit from being cared for early in the morning. Also, no information was found in the resident's chart or plan of care related to any personal care being done daily at 5 am. There was no prior information in the chart indicating that it was the resident's sleep pattern or preference/habit to be up at 5 am, or that his/her SDM / family were aware of the resident being woken, washed, dressed and risen at 5 am and had given consent to this practice. [s. 26. (3) 21.]

2. A review of Resident #1's health care record was conducted by Inspector #551. Resident #1 has resided at the home since 2007 and has a CPS score of 6. The PSW Observational Flow Sheet indicates that the resident requires total assistance with his/her activities of daily living (ADLs). According to the schedule, Resident #1 is on the list for 6 am care on Monday, Tuesday, Thursday and Friday. Resident #1's plan of care did not outline that being dressed and awake as was observed at 06:40 on November 19, 2014 was in accordance with his/her sleep patterns and preferences. There was no information in the resident's chart indicating that the SDM / family were aware of the resident being woken, washed, dressed and risen at 6 am and had given consent to this practice.

A review of Resident #2's health care record was conducted by Inspector #551. Resident #2's diagnoses include dementia and a neurodegenerative disease. The resident's CPS score is 5. Resident #2's plan of care indicates that the resident requires constant supervision and assistance with dressing and total assistance for hygiene and grooming. Resident #002's plan of care did not outline that being dressed in day clothes then being put back to bed as was observed at 06:40 am on November 19, 2014 was in accordance with his/her sleep patterns and preferences. There was no information in the resident's chart indicating that the SDM / family were aware of the resident being woken, washed, dressed and risen at 6 am and had given consent to this practice.

A review of Resident #3's health care record was conducted by Inspector #551. Resident #3's diagnosis includes dementia. The resident's CPS score is 6. According to the PSW Observational Flow Sheet, the resident requires total assistance with his/her ADLS. According to the schedule, the resident is on the list for 5 am care on Tuesday, Wednesday, Friday and Saturday. Resident #3's plan of care did not outline that being dressed in day clothes then being put back to bed as was observed at 06:55 am on November 19, 2014 was in accordance with his/her sleep patterns and preferences. There was no information in the resident's chart indicating that the SDM / family were aware of the resident being woken, washed, dressed and risen at 5 am and had given consent to this practice.

Resident #4 and Resident #5 are on the schedule for 5 am care on Monday, Tuesday, Wednesday, Friday and Saturday.

A review of Resident #4's health care record was conducted by Inspector #551. Resident #4's diagnosis includes dementia. Resident #4's plan of care indicates that the resident

requires constant supervision and assistance with dressing and total assistance for hygiene and grooming. Resident #4's plan of care did not outline that being dressed and awake as was observed at 06:25 am on November 19, 2014 was in accordance with his/her sleep patterns and preferences. There was no information in the resident's chart indicating that the SDM / family were aware of the resident being woken, washed, dressed and risen at 6 am and had given consent to this practice.

A review of Resident #5's health care record was conducted by Inspector #551. Resident #5's diagnosis include dementia and has a CPS score is 5. Resident #5's plan of care indicates that the resident requires constant supervision and assistance with dressing and constant supervision with physical assistance for personal grooming. Resident #5's plan of care did not outline that being dressed, awake and seated in the lounge as was observed at 06:25 am on November 19, 2014 was in accordance with his/her sleep patterns and preferences. There was no information in the resident's chart indicating that the SDM / family were aware of the resident being woken, washed, dressed and risen at 6 am and had given consent to this practice. [s. 26. (3) 21.]

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 for the identified residents, an interdisciplinary assessment of the residents' sleep pattern and preferences be completed, and that these be clearly identified in the residents' plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote rest, comfort and

sleep. [Log #O-001172-14]

Resident #6 is identified as required 2 staff assistance at all times for aspects of his/her activities of daily living. On November 18, 2014, Resident #6's family member expressed concerns to Inspector #117 that the resident was not being put to bed between 7-7:30pm on a nightly basis, as per their expressed wishes for the resident's bed time routine. The family member stated that they had met with the home's administrator in October 2014 to review and revise Resident #6's plan of care related to bed time routines. The family member stated that the administrator had reassured them that the identified bed time routine preferences would be respected to the best of the home's abilities.

On November 18, 2014, Inspector #117 noted that at 07:55pm, Resident #6 was still seated, in a tilted back position, in his/her wheelchair. The privacy curtains were pulled around the resident's bed area, the lights were dimmed and soothing music was playing on the bedside radio. At 08:25pm, Resident # 6 was observed to be resting in bed. Inspector #117 spoke with staff members S#105 and S#106 regarding Resident #6's bedtime routine. Staff member S#105 stated the resident's family member visits every evening. The family member stays approximately 2-3hours visiting on a nightly basis. The staff member stated that, at approximately 07:45pm she provided the resident with partial evening care and finished Resident #6's evening routine when the other staff member S#106 came back from her 8pm break. Both staff members stated that they were aware of the Resident #6's family member's new preference to have the resident in bed between 7-7:30pm. Both PSWs stated that since early October 2014 the resident is usually put to bed between 8-8:30pm due to evening staffing changes.

A review of Resident #6's health care record was conducted. Progress notes show that on a specific day in October 2014, the resident's family member met and spoke with the home's administrator regarding changing the resident's bedtime routine to have the resident in bed between 7-7:30pm instead of between 7:30-8pm as previously identified. Notes indicate that there were no concerns regarding the resident's skin integrity or other care concerns other than the family member's preference to change the resident's bedtime routine due to concerns with the resident's general comfort and need for rest. As per chart documentation, between the day of the meeting in October and the next 13 days, staff were putting resident to bed between 7:20pm and 8:15pm. No documentation was found in the resident's plan of care as it relates to changes in the resident's new bedtime routines to promote rest and comfort, when the family requested that the resident's bedtime to be between 7-7:30pm.

On November 19, 2014, the home's administrator stated to Inspector #117 that she was aware of Resident #6's family member's new preference to have the resident in bed between 7-7:30pm. The Administrator stated that nursing staff were informed of the new preferred bedtime however this was not changed in the resident's plan of care and the administrator was not aware that Resident #6 was still being put to bed after the preferred bed time routine as identified by the resident's family member. [s. 41.]

Issued on this 7th day of January, 2015

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

Original report signed by the inspector.