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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 20, 2017	2017_637500_0007	010744-16, 028660-16, 028738-16, 032535-16, 001426-17, 005976-17	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc
325 Max Becker Drive Suite 201 KITCHENER ON N2E 4H5

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

THE VILLAGE OF HUMBER HEIGHTS
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

NITAL SHETH (500), SABRINA GILL (662), SIMAR KAUR (654), THERESA BERDOE-YOUNG (596)

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): This inspection was conducted on the following date(s): March 22, 23, 24, 27, 28, 29, 30, 31, April 3, 4, 5, 6, 7, 10, 11, 12, 13, 18, 19, 20, 21, 24, 25, 26, 27, 28, May 1, 2, 4, 5, 10, 11, 12, 2017.

During this complaint inspection, following intakes were inspected concurrently:
Critical Incident System (CIS) #025793-16
Complaint #008781-17.

During the course of the inspection, the inspector(s) spoke with General Manager, Assistant General Manager, Director of Nursing (DON), Assistant Director of Nursing (ADON), Resident Assessment Instrument (RAI) Coordinators, Registered Dietitian (RD), Kinesiologist, Physiotherapist, Neighborhood Care Coordinators, Maintenance Technician, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Care Aides (PCAs), Private Care Givers, Residents, and Family members.

During the course of this inspection, inspectors observed residents' care, staff to resident interaction, dining room services, medication administration, reviewed resident health care records and home's records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

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

11 WN(s)
7 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 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 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.

Ministry of Health and Long-term Care received a complaint in 2017. The complaint indicated that the staff do not treat resident #001 with respect and dignity.

Interview with resident #001 revealed that staff did not treat him/her with respect and dignity. Resident #001 indicated that PCA #110, #114, and RPN #118 treated him/her with disrespect. The resident indicated that he/she required staff assistance for an identified care task related to physical limitations.

A review of the resident's written plan of care revealed the resident required total assistance of one staff for the identified care, and identified strategies for the staff.

Voice recording #5 revealed that PCA #110 made some inappropriate comments when the resident requested for assistance. PCA #110 refused to assist the resident and replied to the resident with an inappropriate comment.

Voice recording #8 revealed that PCA #110 provided a time line for the resident to complete the identified care task and would return in a pre-determined amount of time. The resident asked for assistance to complete the task and the PCA made an inappropriate comment.

Voice recording #6 revealed that PCA #114 refused to provide assistance by saying "No" in a rude and loud tone, when the resident asked him/her to provide assistance. PCA#114 indicated the resident to try and complete the task him/herself and made an inappropriate comment.

Voice recording #7 revealed RPN #118 refused to assist the resident with the identified care task. The resident asked RPN #118 to send the care giver to assist him/her. RPN #118 replied with inappropriate comments. During the conversation, RPN #118 had a loud and rude tone of voice.

A review of the copy of an email sent by resident #001 to the Neighborhood Care Coordinator (NCC) #119 revealed the call bell was not answered from 0625 hours to 0725 hours, and finally PCA #109 answered the call bell. When the resident asked a reason for being so late to answer the call bell, PCA #109 made an inappropriate comment.

A review of the response email sent by NCC #119 revealed that he/she apologized to the resident and ensured that it would not happen again.

Interview with PCA #110, and #114 revealed that they should not make inappropriate comments to the resident, it is disrespectful to the resident.

Interview with RPN #118 revealed that he/she made inappropriate comment to the resident, during the conversation his/her tone of voice was loud, and it is disrespectful to the resident. The resident should be treated with respect and dignity.

Interview with PCA #109 revealed that the PCA does not remember the incident regarding a call bell and denied making the above mentioned comment to the resident.

NCC #119 confirmed in the interview that during the investigation PCA #109 confirmed making an inappropriate comment to the resident in regards to the call bell incident and indicated that he/she was joking to the resident. NCC #119 confirmed after listening the above mentioned voice recordings that staff should have treated the resident with respect and dignity.

Interview with AGM revealed that staff should have treated the resident with respect and dignity. [s. 3. (1) 1.]

2. Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff do not treat resident #002 with respect and dignity and making comments about the resident.

A review of the resident #002's written plan of care revealed that the resident had an identified health condition and refused for any interventions. The plan of care indicated staff to refer to the identified staff member for any significant change in the resident's health condition.

Interview with resident #002, revealed that PCA #114 made comments about the resident 's health condition and provided some suggestions to the resident to manage his/her condition. The resident indicated that he/she had felt very bad, and staff should not make any comments about his/her health condition and provide any suggestions.

Interview with resident #002's family member revealed that PCA #114 had made inappropriate comments about the resident's health condition and the resident was very upset with it.

Interview with PCA #114 revealed that he/she made some comments and provided suggestions to the resident.

Interview with PCA #110 revealed that during their staff meeting, it was indicated that PCA #114 made comments about the resident's health condition and they should not do it, if there is any concern regarding the resident's health condition, it should be communicated to the registered staff on the unit.

Interview with NCC #119 revealed that during the investigation the home found that PCA #114 had made inappropriate comments about the resident's health condition, any concern related to the resident's health condition should have been communicated with the registered staff, and staff should treat the resident with respect and dignity.

Interview with AGM revealed that staff should have treat the resident with respect and dignity. [s. 3. (1) 1.]

3. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent.

Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff did not respect the resident #001's right to refuse a shower.

Interview with resident #001 revealed that on an identified day, PCA #114, and #116 did not respect his/her right to refuse a shower. The resident indicated, on that day in the morning he/she agreed to have a shower after been refusing for two months. He/she was on the way to the shower room, when the resident required to use the washroom. The resident asked the PCAs to stop transferring him/her to the shower room. Staff did not stop and showered the resident.

A review of the CIS report revealed the resident provided a statement that PCAs continued to provide him/her a shower even though he/she refused. The CIS report indicated that PCA #116 encouraged the resident and continued on the shower, despite the resident's protest.

The inspector could not complete interview with PCA #116 as he/she is no longer employed with the home.

Interview with PCA #114 revealed that they continued with the shower as the resident was already ready for a shower and he/she was refusing a shower from a long time,

despite the refusal of the resident.

A review of the home's policy #04-06, entitled, "Spa (Shower-Tub Bath- Sponge Bath), reviewed February 1, 2016, indicated when a resident declines their spa after multiple attempts and negotiation, it must be documented on the PSW flow sheet under bathing. PSW will report it to the team leader and the team leader will document the reason for refusal and alternative interventions tried without success. If the resident refused today, offer their spa the following day or later in the shift.

Interview with NCC #119, and AGM revealed that staff have to respect the resident's right to refuse a care. Staff should have stopped when the resident started refusing a shower. [s. 3. (1) 11. ii.]

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 following rights of residents are fully respected and promoted:

- 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
- Every resident has the right to give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent, 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. (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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A complaint was submitted to MOHLTC, indicated resident #012 was not provided bath according to preference.

Record review of resident #012's written plan of care indicated that the resident had an identified health condition and identified a method of bathing twice in a week.

Interview with resident #012 revealed that he/she had a preferred method of bathing, and was provided an alternate method instead. Resident indicated that he/she had indicated this preference in the previous year. The resident further indicated that he/she had been informed by a staff that the home was not able to accommodate the resident's preferred method of bathing as the home did not have the appropriate equipment.

The resident further indicated that he/she had not received any assessment for the use of this equipment.

Interview with the PSW #121 indicated that resident #012 had an identified health condition. He/she had been provided with an identified method of bathing as he/she had required a particular equipment to be provided him/her preferred method of bathing.
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Interview with RPN #126 indicated that he/she had been informed by resident #012 of his/her preference a few weeks ago. The RPN had spoken to NCC #124, and had been informed that the resident required a particular equipment.

Interview with the RPN #126 and NCC #124 indicated that as per the home's procedure registered staff should send a referral to Kinesiologist if residents require any special equipment for ADLs. The RPN and NCC further confirmed that there had not been a referral sent to Kinesiologist for resident #012's assessment.

Record review of resident #012's progress notes and clinical file did not indicate an assessment for the use of the particular equipment.

Interview with the Kinesiologist #129 confirmed that he/she had not received any referral for resident #012's assessment.

Interview with DOC and NCC #124 revealed that resident #012's plan of care was not based on an assessment of the resident and the resident's needs and preferences as required. [s. 6. (2)]

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

Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff refused to provide nutritional intervention to resident #001.

Interview with resident #001 revealed that staff refused to provide nutritional intervention on more than one occasion. The resident had a conversation with the RD, and RD indicated to the resident that he/she can ask for nutritional intervention when he/she required.

A review of the progress note revealed that RD placed an order to provide nutritional intervention three times a day. Staff to ask the resident if he/she would like to have nutritional intervention if the meal is refused.

Voice recording #9 revealed that PCA #115 refused to provide nutritional intervention to the resident on and identified day. The resident indicated that he/she will not eat his/her dinner and if the PCA can provide him/her the nutritional intervention. PCA #115 replied

the nutritional intervention would not be provided.

Voice recording #10 revealed that PCA #115 refused to provide nutritional intervention on another identified day. PCA indicated to the resident that the resident had to eat the meal and the nutritional intervention would be provided contingent on how much of the meal the resident consumed.

A review of the nutrition and hydration flow sheet revealed that the resident had refused meals on the above mentioned days, and had meals less than 50%. Based on the resident not having dinner, and lunch, he/she was eligible to have nutritional intervention, as the meal intake was less than 50 percent, and did not receive the nutritional intervention.

Interview with PCA #115 revealed that as per the care plan if the resident is eating less than 50 percent than he/she will get a nutritional intervention, if the resident refused meal, than they do not provide a nutritional intervention. The resident has to make an attempt to eat dinner to have nutritional intervention.

Interview with RPN #118 and NCC #119 revealed that when the resident eat less than 50 percent than he/she will get a nutritional intervention, as per the order.

Interview with RD revealed that the resident should have received a nutritional intervention upon a refusal of the meal. RD indicated that the resident refused the meal that is 0 percent and it is less than 50 percent therefore the resident qualifies to get a nutritional intervention as per the order written in the plan of care.

A review of the resident's written plan of care revealed that on an identified day, RD placed a new order to provide nutritional intervention three times a day as needed only if meal is taken less than 50 percent.

Interview with AGM revealed that staff should have followed the resident's plan of care. [s. 6. (7)]

3. A review of the resident's written plan of care revealed that the resident was at high nutritional risk. RD recommended to provide an identified volume of a nutritional intervention three times a day.

Observation on April 26, 2017, at 1730 hours, resident #017 was found sitting in the

dining room, served with nutritional intervention in a small medication cup. The inspector identified that the cup was small and could not fill the identified volume as per the plan of care.

Interview with RPN #159 indicated that they are using the medication cup to provide nutritional intervention to the resident and it is the identified volume. RPN measured the cup by using water with a measuring cup. The cup filled to the rim with 5 ml less than the identified volume. RPN confirmed that the nutritional intervention provided to the resident was not enough.

A review of the home's policy #07-49 indicated that the identified nutritional intervention will be offered and will document on the MARS (Medication Administration Records) to indicate how much was ingested by the registered nursing team.

Interview with RD revealed that the order is very specific to provide identified volume of nutritional intervention three times a day. RPN should have measured and provided the identified volume of nutritional intervention to the resident as indicated in the plan of care.

Interview with AGM revealed that staff should have followed the resident's plan of care. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A complaint was submitted to MOHLTC, indicated resident #012 was not provided bath according to preference.

Record review of resident #012's written plan of care, indicated that resident had an identified health condition and preferred to have an identified method of bathing twice in a week.

Record review of the home's personal care observation and monitoring form indicated that there had been no documentation for resident #012's bath on two days.

Interview with PSW #121 revealed that resident #012 required two staff assistance with identified method of bathing, and he/she had assisted the resident's primary care giver with the resident's identified method of bathing on evening shifts on the above mentioned

dates. The PSW further indicated that her primary care giver had forgotten to document on the form for the above mentioned days.

Interview with resident indicated that he/she had received identified method of bathing on above mentioned dates during a specific time period.

Interview with the RPN #126 and DOC confirmed that as per the home's expectation all PSWs are responsible to document type of bath, assistance and number of staff required on personal care observation and monitoring form. DOC further confirmed that the provision of care set out in the plan of care of resident #012's was not documented on March 28, and 31, 2017, as required. [s. 6. (9) 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 to ensure that,
- the plan of care is based on an assessment of the resident and the resident's needs and preferences
- the care set out in the plan of care is provided to the resident as specified in the plan
- the provision of care set out in the plan of care is documented, to be implemented voluntarily.

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:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

Record review of a complaint called into the MOHLTC info line, revealed a concern about resident #021's fall. The resident sustained an injury. Review of CI report submitted by the home to the MOHLTC revealed a PCA had assisted resident #021 to bed then later discovered the resident around on the floor of his/her room with injury. Resident #021 remained in hospital during this inspection as a result of the injury.

Review of the resident's progress notes revealed that the resident had four falls in four months.

According to a resident's Falls Risk Assessment, the resident was deemed at moderate risk for falls.

Review of resident #021's Falls Incident report revealed that the resident had a fall in his/her room and was discovered on the floor close to the bed by a PCA; the resident sustained an injury.

Review of the resident's clinical record revealed no care plan or interventions related to moderate risk for falls. The resident's personal care profile located in the PCA flow sheet binder also did not include any falls risk interventions or identify the resident as moderate risk for falls.

According to PCA # 115 and #110 resident #021 was high risk for falls. RPN # 118 stated that the resident was between moderate to high risk for falls. PCA #110 and RPN #118 stated that the resident's falls risk and interventions were not included in the plan of care or the personal care profile kept in PCA flow sheet binder.

Interview with the DOC and AGM revealed that the home's expectation was that the Kinesiologist or the RAI Coordinator #122 should have initiated a Falls Risk care plan including individualized interventions for resident #021 due to the moderate risk for falls, and it was missed. [s. 26. (3) 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 ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls, to be implemented voluntarily.

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 of has failed to ensure that, (a) a care conference of the interdisciplinary team providing a resident's care was 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; (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 (c) a record is kept of the date, the participants and the results of the conferences.

Ministry of Health and Long-term Care received a complaint, the complaint indicated that resident #001 had no care conference conducted.

Interview with resident #001 revealed that he/she had no care conference with interdisciplinary team. Only one time, he had a conference with a social worker and NCC #119, but there were no other people present.

A review of progress notes revealed that the resident was not offered annual care conference in 2016. The resident was offered six week conference on February 3, 2015, based on the progress notes.

A review of the home's policy #04-18, entitled "Care Conferences (Move-In & Annual), reviewed March 25, 2017, indicated the care conference will be schedule to occur within six weeks of the resident's move-in and annually thereafter and as needed.

Interview with NCC #119 revealed that he/she did not remember scheduling or conducting the annual care conference for the resident in 2016.

Interview with AGM revealed that the resident should have an annual care conference conducted in 2016. [s. 27. (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 to 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; (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 (c) a record is kept of the date, the participants and the results of the conferences, to be implemented voluntarily.

WN #5: 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 was 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.

Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff were refusing to bathe to resident #001.

Interview with resident #001 revealed that staff refused to bathe the resident. There are some days, when he/she refused a shower but not always.

A review of the shower schedule-1 revealed that the resident was scheduled for evening shower twice a week. The resident's preference for morning shower was not considered

until nine months.

A review of the resident's written plan of care revealed that the resident prefers to have shower two days per week in the morning.

A review of voice recording #1 and #2 revealed that PCA #116, refused to shower resident #001 on two days.

According to voice recording #1, #2, #3, and #4 revealed that PCA #116, #114, and #113 refused the resident to provide bathing care on different occasions by giving different reasons.

A review of the documentation record entitled "Personal Care Observation and Monitoring Form" for resident #001 revealed that the resident did not receive two showers for three identified weeks.

The inspector could not interview PCA #116 as the PCA #116 is no longer employed at the home.

Interview with PCA #109, #110, #114, #115, and RPN #118 revealed that they provide shower to residents only on their scheduled days. If the resident refused a shower it will be offered only on the next scheduled day. As per the policy they need to offer an identified bathing care to residents, however they do not provide identified bathing care to resident #001 because he/she complaints about pain.

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A review of the home's policy #04-06, entitled, "Spa (Shower-Tub Bath- Sponge Bath), reviewed February 1, 2016, indicated the home to provide a choice of a spa experience (bath, shower, or bed bath) to cleanse, refresh, and relax the resident, and to stimulate the circulation at a minimum of two per week as per the resident's needs/ requests. The PSW will invite the resident for a spa of their choice. Explain the process to the resident and assist them to the spa area depending on their needs. Involve the resident in the spa experience, ask their preference with washing. When a resident declines their spa after multiple attempts and negotiation, it must be documented on the PSW flow sheet under bathing. PSW will report it to the team leader and the team leader will document the reason for refusal and alternative interventions tried without success. If the resident refused today, offer their spa the following day or later in the shift.

Interview with NCC #119 revealed that resident #001 refused his/her showers because many times, he/she would say he/she is too busy, or some appointments and would not be able to get a shower. Staff to offer him two showers a week, and if he/she refused staff to offer a sponge bath. If the resident refused, it should be offered on next day. For this resident, we asked staff to offer shower when the resident request due to his/her history of refusals.

Interview with AGM revealed that the resident should have provided shower twice a week. [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 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of a complaint called into the MOHLTC revealed a concern about resident #021's fall. The resident was transferred to hospital and remained in hospital during this inspection, as a result of injuries sustained from the fall.

Review of resident #021's Falls Incident report revealed that the resident had a fall.

Review of the resident's progress notes revealed that the resident had four previous falls in four months.

Record review of resident #021's clinical record revealed that a post falls follow up report was not completed after the resident had fallen.

Interview with RPN #118 revealed she worked on the day of the fall and should have completed the resident's post falls follow up documentation; somehow he/she missed it and did not complete it.

Interview with the AGM reported that the home's expectation is that registered staff complete a post falls follow up report after every resident's fall, and it was not completed for resident #021 after he/she fell in 2017. [s. 49. (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 ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tear or wounds, has been reassessed at least weekly be a member of the registered nursing staff.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to the management of resident #020's impaired skin integrity.

Review of resident #020's progress notes indicated that resident was noted to have an impaired skin integrity. Review of Physician Order indicated orders for an identified treatment every two days and as required. Review of resident #020's Treatment Administration Record (TAR) indicated the treatment every two days and as needed. Review of progress notes indicated that resident #020 was assessed by the Registered Dietitian (RD) and supplementation was recommended. Further review indicated that the weekly assessments were not completed for 11 weeks in 2015, 31 weeks in 2016 and one week in 2017 for resident #020's impaired skin integrity.

Interviews with RPN #118 and #164 indicated that once registered staff are made aware of a skin related concern the home's expectation is for registered staff to complete an assessment, notify the physician and initiate the treatment as ordered. RPN #118 and #164 further indicated that for residents with skin concerns, registered staff are to

conduct a weekly assessment of these concerns that is documented on the Assessment Tool and also a note is documented in the progress notes. [s. 50. (2) (b) (iv)]

2. Review of resident #022's progress notes indicated that resident was noted to have an impaired skin integrity and a referral was made to the skin care nurse and physician was notified. Review of resident #022's Treatment Administration Record (TAR) revealed a treatment every two days and as needed. Review of resident #022's care plan dated revealed that resident #022 is at risk for altered skin integrity and staff are to complete a skin assessment at least twice weekly on resident bath days to assess the skin and document on the skin assessment form. Further record review indicated that the weekly assessments were not completed for four weeks in 2017.

Interviews with PSW #113 and RPN #165 indicated that once registered staff are made aware of a skin related concern the home's expectation is for registered staff to complete an assessment, notify the physician and initiate the treatment as ordered. RPN #165 further indicated that for residents with skin concerns, registered staff are to conduct a weekly assessment of these concerns that is documented on the Assessment Tool and also a note is documented in the progress notes. RPN #165 reported that he/she did not complete the Assessment Tool for the week of April30, 2017, and an assessment should have been done. [s. 50. (2) (b) (iv)]

3. Review of resident #023's progress notes indicated that the resident was noted to have impaired skin integrity and a referral was made to the skin care nurse. Further review of the progress notes revealed that resident #023 was started on a specific therapy. A review of resident #023's plan of care indicated that resident #023 is at risk of altered skin integrity and staff are to complete a skin assessment at least twice weekly on resident bath days to assess the skin and document on the skin assessment form. The care plan also indicated that resident #023 requires adequate protein intake from food to promote healing and to prevent further skin issues. Further record review indicated that the weekly assessments were not completed for the resident #023's for seven weeks in 2016 and 14 weeks in 2017.

Review of the home's Skin Care Program last revised December 8, 2016, under roles and responsibilities of registered staff states, "...assesses altered skin integrity weekly and documents within the assessment for injuries".

Interviews with PSW #167 and RPN #166 indicated that once registered staff are made aware of a skin related concern the home's expectation is for registered staff to complete

an assessment, notify the physician and initiate the treatment as ordered. RPN #166 further indicated that for residents with skin concerns, registered staff are to conduct a weekly assessment of these concerns that is documented on the Assessment Tool and also a note is documented in the progress notes.

An interview with the Skin Care Lead #122 and the DOC indicated that once registered staff are notified of a skin concern, the registered staff are to conduct an assessment of the skin concern which is documented on the Skin Assessment Concern Form, notify the physician and obtain orders, update the Treatment Administration Record (TAR). Skin Care Lead #122 and the DOC further indicated that registered staff are to complete weekly assessments for identified impaired skin integrity and document on the Assessment Tool on a weekly basis. Skin Care Lead and the DOC acknowledged that the weekly Assessment Tool was not completed for the above mentioned residents on the above mentioned weeks and a weekly Assessment Tool should have been completed. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tear or wounds are reassessed at least weekly be a member of the registered nursing staff, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received preventive

and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff were refusing to provide nail care to resident #001.

Observation on an identified day revealed that resident #001 had long nails.

Interview with resident #001 revealed that staff refused to provide nail care to him/her.

A review of the resident's written plan of care revealed that the resident required assistance with the nails and staff to provide nail care to the resident.

A review of the documentation record entitled "Personal Care Observation and Monitoring Form" for resident #001 revealed that the resident was not documented as being provided nail care during in three months period.

Interview with PCA #115 revealed that staff have to provide nail care when the resident requests.

Interview with PCA #114 revealed that the resident required total assistance for nail care. The resident requested for nail care and he/she refused it, because the resident had long and hard nails and required a specialized nurse. The resident does not allow staff to touch his/her due to pain.

Interview with PCA #110 revealed that he/she refused to provide nail care to the resident because he/ she is complaining about pain and the resident required a specialized nurse to cut his/her nails.

Interview with RPN #118 revealed that staff have to provide nail care to the resident as per the home's policy. The resident is refusing nail care, and now the resident has thick nails and required a specialized nurse.

A review of the home's policy #04-06, entitled, "Spa (Shower-Tub Bath- Sponge Bath), reviewed February 1, 2016, indicated after bathing is completed provide nail care to feet and hands. A registered team member will provide nail care to diabetic residents.

Interview with Neighborhood Care Coordinator #119 revealed the home is currently

revising the plan of care related to bathing this resident. The Neighborhood #119 Care Coordinator indicated that once he/she resolve this issue, the next step is to refer to the specialized nurse.

A review of the resident's written care plan revealed that the foot care nurse was not referred until a specific day.

Interview with AGM revealed that staff should have provided basic nail care to the resident. [s. 35. (1)]

WN #9: 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: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: sufficient time for every resident to eat at his or her own pace.

Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff are not providing enough time to resident #001 to complete an identified care task.

Interview with resident #001 revealed that staff refused to provide enough time to

complete an identified care task and provide him/her a timeline of 45 minutes.

A review of the resident's written plan of care revealed that resident required total assistance of one person with all meals that takes about 30 minutes to one hour per meals.

Voice recording #6, and #8 revealed that PCA #114, and #110 provided 45 minutes of timeline for the resident to finish his/her meals on two different occasions, when the resident asked for assistance both refused to provide assistance to complete an identified task.

Interview with PCA #110, PCA #114 and Neighborhood Care Coordinator #119 revealed that they are providing the resident 45 minutes to finish identified tasks, because they have to complete documentation for meal intake before the end of the shift.

Interview with RD and AGM revealed that the resident should have enough time to finish his/her identified tasks. [s. 73. (1) 7.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: providing residents with personal assistance required to safely eat and drink as comfortably and independently as possible.

Ministry of Health and Long-term Care received a complaint. The complaint indicated that the staff are refused to provide assistance to resident #001.

Interview with resident #001 revealed that staff refused to provide assistance.

A review of the resident's written plan of care revealed that the resident needs total assistance to complete an identified task related to a health condition.

Voice recording #8 and #5 revealed that PCA #114, and PCA #110 made inappropriate comments and refused to assist the resident to complete an identified task.

Interview with PCA #114 and PCA #110 revealed that the resident always required one person assistance to complete an identified task and staff want the resident to be independent and therefore they refused to provide assistance to the resident to complete an identified task.

Interview with Neighborhood Care Coordinator #119 revealed that the resident is able to complete an identified task self, but asks for assistance.

Interview with an identified staff revealed that if the resident asked for assistance, it is a part of his/her health condition and the resident should have received assistance to complete an identified task.

Interview with AGM revealed that staff should have assisted the resident. [s. 73. (1) 9.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were provided training in skin and wound care.

The home's training records and an interview with the DOC #101 revealed that 136 out of 169 (80%) of direct care providers completed training in the Skin and Wound Care Program in 2016. [s. 221. (1) 2.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (6) The licensee shall ensure that the emergency plans for the home are evaluated and updated at least annually, including the updating of all emergency contact information. O. Reg. 79/10, s. 230 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure the emergency plans for the home was evaluated and updated at least annually, including the updating of all emergency contact information.

A complaint was submitted to MOHLTC, involving a concern related to the home's emergency plans, and use of a defibrillator in the home in case of a medical emergency.

Record review of the home's emergency plans and interview with the Assistant General Manager (AGM) of the home confirmed that the home had not evaluated and updated emergency plans, including all emergency contact information in 2016. AGM further indicated that he/she had joined as AGM in the home from January 2017, and does not have any record of when the emergency plans for the home had been evaluated and updated last. [s. 230. (6)]

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.