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 sions 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
May 1, 2017	2017_570528_0014	028320-15, 006672-17	Complaint

Licensee/Titulaire de permis

HALDIMAND WAR MEMORIAL HOSPITAL
206 JOHN STREET DUNNVILLE ON N1A 2P7

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

EDGEWATER GARDENS LONG TERM CARE CENTRE
428 BROAD STREET WEST DUNNVILLE ON N1A 1T3

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

CYNTHIA DITOMASSO (528)

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): April 13, 18, 19, 20, 2017

This complaint inspection included log #006672-17 related to multiple concerns of resident care and services and 028320-15 related to sufficient staffing follow up; and was completed concurrently with follow up inspection # 2017_570528_0013.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Business Office Manager/Scheduler, Food Service Supervisor (FSS)/ Director of Housekeeping and Laundry, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents and families.

During the course of the inspection, the inspectors also observed the provision of care and services, reviewed relevant documents including but not limited to, clinical health records, policies and procedures, investigation notes, staffing schedules, complaints log

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A. In 2017, resident #010 was admitted to the home. Review of the plan of care for the resident identified that the assessments of the resident's bowel status between the interdisciplinary team did not complement each other.

i. A Bowel and Bladder Continence Assessment identified that the resident had a history of irregular bowel movements, and medications was ordered to promote regular bowel management.
ii. Point of Care (POC) was reviewed and revealed that a bowel movement was not documented for for several days.
iii. The registered staff's "Bowel Monitoring List" did not correspond to the POC documentation. Interview with RPN #100 confirmed that the registered staff and PSW bowel documentation did not complement each other, related to how many days the

resident went without having a bowel movement.
iv. A RD assessment in 2017, reported that the resident's bowel movements had been regular. Interview with the FSS confirmed that the resident was admitted with a history of bowel irregularity, which was not identified in the RD assessment.
v. Interview with the DOC and review of the progress notes, confirmed that the resident had a history of irregular bowel movements.
The bowel assessments of the resident from registered staff, PSW staff and the RD were not consistent with and did not complement each other, related to bowels. (528)

B. The plan of care for resident #011 identified that the resident required monitoring for irregular bowel management and required interventions, which included administering medications to the resident depending on how many days the resident went without a bowel movement.

i. Review of Point of Care (POC) PSW documentation from 2017, revealed that the resident did not have a bowel movement for several days
ii. Review of the registered staff documentation titled "Bowel Monitoring List", revealed that the days the resident went without bowel movements did not match the POC documentation. Interview with RN #106 confirmed that the PSW's POC documentation and registered staff's "Bowel Monitoring List" documentation were not consistent with and did not complement each other in relation to how many days resident #011 went without a bowel movement. (528) [s. 6. (4) (a)]

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

A. The plan of care for resident #010 identified that the resident required thickened fluids. On the following occasions staff were observed providing the resident with a thicker beverage than required:

i. On an identified day in April 2017, the resident was provided a choice of beverage. A styrofoam cup was filled three quarters (3/4) of the way full with juice; PSW #101 added a thickening agent and then allowed the beverage to sit and thicken.
Interview with PSW #101 revealed that they thought the cup help approximately 250 mls of fluid and was adding too much of the thickening agent to obtain the appropriate thickened consistency for resident #010. Interview with the FSS confirmed that a styrofoam cup only held 125 mls of fluid and the amount of thickening agent added to the beverage by PSW #101 would create a thicker beverage than resident #010 required, as

specified in their plan.

ii. On an identified day in April 2017, at lunch service, PSW #103 provided resident with a pre-thickened juice beverage of greater consistency than required in the plan of care. Interview with PSW #103 confirmed that thickened consistency was provided, which was thicker than required in resident #010's plan of care. At lunch service pre-thickened juice beverages were observed in the fridge that were the thickness consistency that was required by resident #010.

iii. On an identified day in April 2017, approximately 75 mls of a juice beverage was observed in the resident's room which was greater consistency than the resident required. Interview with PSW #104 confirmed that they had added a thickening agent to half a styrofoam cup full of juice, and that the consistency was greater than required in the resident #010's plan of care.

B. The plan of care for resident #011 identified that due to a decline in eating the resident required thickened fluids.
i. On an identified day in April 2017, PSW #101 was observed added a thickening agent to approximately 75 mls of juice (a styrofoam cup, half full). The cup was then placed in the resident's room to thicken. Interview with PSW #101 revealed that they thought the cup held 250 mls and therefore added more of the thickening agent than required in the resident's plan of care.

Interview with the FSS confirmed that the cups used in the above observations held approximately 125 mls of fluid and staff were to be using pre-thickened beverages available in the fridge and not to be adding thickener to fluids, as they were unable to obtain a consistent texture. Furthermore, "Thicken-Up" should not be placed on the beverage carts to prevent staff from using the thickener. The FSS stated that staff were to use the thickening agent for coffee only. Interview with the FSS and observations confirmed that the home had containers of pre-thickened beverages available in the appropriate consistency for the staff to dispense for residents. (528)

C. The plan of care for resident #011 directed staff to monitor the resident for bowel changes. Interventions included but were not limited to, if the resident did not have a bowel movement to follow the bowel protocol, which included a three step medication administration depending how many days the resident went without a bowel movement.

i. Review of the home's "Bowel Monitoring List" and POC identified that the resident went

without a bowel movement for several days in March 2017.
ii. Review of the electronic medication administration record (eMAR) showed that the bowel protocol was not administered as outlined in the resident's plan of care.
iii. Interview with RN #100 confirmed that according to the eMAR, the bowel protocol was not followed when the resident did not have a bowel movement.

Interview with the DOC confirmed that registered staff were not following the bowel protocol as ordered when resident #011 did not have a bowel movement in March 2017. (528)

D. The plan of care for resident #010 identified that the resident had irregular bowel management. The resident required routine bowel medications including and was placed on a bowel protocol, which included a three step medication administration depending on how many days the resident went without a bowel movement.

i. Review of the home's "Bowel Monitoring List" and POC identified that the resident went without a bowel movement for several days in March 2017.
ii. Review of the electronic medication administration record (eMAR) did not include the administration of any medications following the bowel protocol when the resident went without a bowel movement.

Interview with RPN #100 and the DOC confirmed that the staff did not follow the bowel protocol for resident #010 when they went without a bowel movement for several days. (528)

E. On an identified date, RPN #108 make a comment to resident #017 that was stated in a manner that was intended by the RPN to be light and joking. In a conversation with the resident and their SDM on April 20, 2017, they felt that RPN #108's comments were inappropriate and hurt the resident's feelings.

i. The plan of care for resident #017 identified that the resident had cognitive impairment, as a result, the staff was directed to communicate with the resident in a certain manner.
ii. Interview with the DOC and RPN #100 confirmed that the resident required a certain approach when being spoken to and although the comments from RPN #108 were not meant to hurt the resident, they were inappropriate. (528) [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's

care needs changed or care set out in the plan was no longer necessary.

A. On an identified day in April 2017, resident #010 was observed seated in their wheelchair in their room. The call bell was sitting on the bed and not within the resident's reach. At that time, the resident reported to LTC Homes Inspector #528 that they required the assistance of staff and confirmed they could not reach the call bell. The call bell was activated and staff came to the room approximately five minutes later. PSW #103 confirmed that the resident's call bell was not within reach and the resident could not communicate to staff that they had to use the bathroom. The resident verbally reported to the PSW, three times, that they had to go to the bathroom.

i. In 2017, resident #010 admission assessment completed by Community Care Access Centre (CCAC) revealed that the resident was continent of both bladder and bowels, did not require the use of a continent product, and was able to communicate their needs. The written plan of care for the resident identified that the resident required total assistance with toileting before and after meals and at bedtime.

ii. Review of the Point of Care documentation identified that approximately a week after the resident was admitted to the home, the staff had documented that the resident was incontinent almost daily. As a result of ongoing concerns from the resident's substitute decision maker (SDM), in April 2017, the physician ordered a change to the toileting plan and; however, the written plan of care was not updated to include the new toileting plan. Interview with RPN #100 confirmed that the written plan of care was not updated when the toileting plan changed. (528) [s. 6. (10) (b)]

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 the following:
i. that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,
ii. that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

Note: In this section "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals

In April 2017, anonymous concerns were reported to the Ministry of Health and Long Term Care, that there had not always been a registered nurse(RN) in the home.

Review of the staffing schedules identified that on the following days an RN was not working in the home 10 percent (%) of the time over a three month period:

i. January 22, 2017 and February 24, 2016 from 0700 to 1500 hours
ii. February 18, 2017 and March 23, 24, 28, 2017 from 2300 to 0700 hours
iii. February 23, 2017, March 13, 14, 15, 16, 2017 and April 11, 2017 from 1500 to 2300 hours

Interview with the Administrator/DOC confirmed that in all the above cases the home could not find a replacement for the RN, who was scheduled but could not attend work; and an RPN was called in to replace the RN. It was also reported that this was an ongoing challenge within the home, that although the home had all RN staffing lines filled, including extra staff to call when in need and Agency staff, there were still times when the home could not replace the scheduled RN. (528) [s. 8. (3)]

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 at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee failed to ensure that all areas where drugs are stored were kept locked at all times, when not in use.

On an identified date in April 2017, the medication room behind the nurses station was observed to be unlocked and the door was open. The medication cart in the medication room was also unlocked and the LTC Homes Inspector was able to open the medication drawers of the medication cart, including but not limited to, the narcotic bin. The RN was seated in the next room charting on the computer and one resident was ambulating around the nurses station. When RN #106 returned to the medication room, they confirmed that the narcotic bin, medication cart and medication room should have been locked when unattended. (528) [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #4: 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 failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. The plan of care for resident #011 identified that the resident required assistance with bathing. Review of Point of Care (POC) from February to April 2017, revealed the resident did not receive the minimum bathing requirements on three occasions. Interview with PSW #101, #103, #110, #105 confirmed that occasionally, due to emergencies on the floor and running out of time, the residents missed their scheduled bath day. PSW staff could not confirm on specific days why bathing was not documented; however, clarified that resident's bathing was not documented due to the electronic record not being updated with their current schedule. Interview with DOC confirmed that resident #011 electronic record reflected the bath schedule and was not one of the resident's affected by the online documentation issue and they also confirmed that the home did not work short on the above days.

B. The plan of care for resident #013 identified that the resident required assistance for bathing. Review of POC documentation from February to March 2017, for bathing revealed that the resident did not receive the minimum requirement for bathing on three occasions. Interview with PSW #101, #103, #110, #105 confirmed that occasionally, due to emergencies on the floor and running out of time, the residents missed their scheduled bath day. PSW staff could not confirm on specific days why bathing was not documented; however, clarified that resident's bathing was not documented due to the electronic record not being updated with their current schedule. Interview with DOC confirmed that resident #014 electronic record reflected the bath schedule and was not one of the resident's affected by the online documentation issue and they also confirmed that the home did not work short on the above days.

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 is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan was implemented.

A. On an identified day in April 2017, resident #010 was observed seated in their wheelchair in their room. The call bell was sitting on the bed and not within the resident's reach. At that time, the resident reported to LTC Homes Inspector #528 that they required the assistance of staff and confirmed they could not reach the call bell. The call bell was activated and staff came to the room approximately five minutes later. PSW #103 confirmed that the resident's call bell was not within reach and the resident could not communicate to staff that they had to use the bathroom. The resident verbally reported to the PSW, three times, that they had to go to use the bathroom.

i. In 2017, resident #010 was admitted to the home being continent of both bladder and bowels, did not require the use of a continent product, and was able to verbally tell staff

when they needed to be toileted. The written plan of care for the resident identified that the resident required total assistance with toileting before and after meals and at bedtime.

ii. Interview with PSW#103 #104 confirmed that the call bell was to be left within reach and that staff often reminded the resident how to use the call bell, and when prompted, the resident could press the call bell. However, interview with PSW #104, DOC and the resident's SDM, revealed that the resident had not actually used the call bell to call for assistance and they were unsure that the resident was cognitvely able to understand when to use the bell, but could not identify any additional communication interventions for the resident. Review of the care plan did not include any other interventions related to the resident's communication abilities and how the resident was to communicate their needs with staff, related to toileting.

iii. Review of the Point of Care documentation identified that after approximately a week after the resident was admitted to the home, the staff had documented that the resident was incontinent almost daily. As a result of ongoing concerns from the resident's substitute decision maker (SDM), in April 2017, the physician ordered a change to the toileting plan and identified the resident to be toileted every four hours; however, the written plan of care was not updated to include the new toileting plan. Interview with RPN #100 confirmed that the written plan of care was not updated when the toileting plan changed.

iv. Furthermore, interview with staff confirmed that the resident had had a change in their continence levels. RN #106 revealed that it could potentially be related to disease progression or positioning and the DOC revealed that the change may be related to behaviour, positioning when toileting, or disease progression; however, the home had not completed any further assessments to determine the cause of the change in the resident's continence. (528)

B. The plan of care for resident #011 directed staff to monitor the resident for bowel changes. Interventions included but were not limited to, if the resident did not have a bowel movement to follow the bowel protocol, which included a three step medication administration based on how many days the resident went without a bowel movement. Review of the home's "Bowel Monitoring List" and POC identified that the resident went without a bowel movement for several days. Review of the progress notes did not include any abdominal assessment of the resident. The home's policy "Continence Care and Bowel Management: N-8-150" dated February 2015, directed registered staff to

monitor the resident intake and bowel and bladder functioning and evaluate to determine if the continence care strategies are effective.
Interview with RN #106 confirmed that the resident had constipation and an abdominal assessment was not completed when the resident's care needs changes, related to bowel movements. (528)

C. In March 2017, resident #010 was identified to have bowel irregularity. Interventions included but were not limited to, routine bowel medications; and in addition, if the resident did not have a bowel movement to follow the bowel protocol, which included a three step medication administration based on how many days the resident went without a bowel movement.
Review of the home's "Bowel Monitoring List" and POC identified that the resident went without a bowel movement for several days. Review of the progress notes did not include any abdominal assessment of the resident. The home's policy "Continence Care and Bowel Management: N-8-150" dated February 2015, directed registered staff to monitor the resident intake and bowel and bladder functioning and evaluate to determine if the continence care strategies are effective.
Interview with RN #100 confirmed that the resident had constipation and an abdominal assessment was not completed when the residents care needs changed, related to bowel movements. (528)

D. Interview with RN #106 RPN #100 and DOC confirmed that an assessment should have been completed when a resident was not having regular bowel movements, including but not limited to, inspection of the abdomen, auscultation for bowel sounds, light palpation, and reviewing flood and fluid intake. (528) [s. 51. (2) (b)]

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 who is incontinent have an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that plan is implemented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the licensee immediately forwarded any written complaints that had been received concerning the care of a resident or the operation of the home to the Director.

In March 2017, the Adminsitrator/DOC received a written complaint from the SDM of resident #010 concerning the care of the resident. Review of the Director's records did not include the written complaint. Interview with the Administrator/DOC confirmed that the written complaint was not submitted to the Director, as they were unaware of the requirement. (528) [s. 22. (1)]

WN #7: 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 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 were documented.

During the course of the inspection resident #010 was observed being provided assistance with bathing. Review of Point of Care (POC) documentation for bathing did not include any documentation that the resident was bathed or provided nail care for the first five weeks while the resident lived at the home. Interview with PSW #101, #103, and the DOC confirmed that the resident had been bathed and provided nail care every twice a week but the electronic records were not updated so that the PSW staff could document the care. (528) [s. 30. (2)]

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. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received fingernail care, including the cutting of fingernails.

On an identified day in April 2017, resident #010 was assisted to shower, as scheduled. After the resident's shower, their fingernails were observed to be long and untrimmed. Interview with PSW #102 confirmed that the resident was not provided finger nail care when they were bathed, as required. Interview with RN #106 confirmed that all residents should receive routine nail care on scheduled bath days. (528) [s. 35. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the residents' linens were changed at least once a week, and more often as needed.

On an identified day in April 2017, in the morning, small stains were observed on one side of resident #010's pillow case. The resident was assisted to shower and after lunch their bed was made, which included a clean fitted sheet. However, the pillow case was observed and noted to be turned over with the stained side facing the bed.

On an identified day in April 2017, in the afternoon, small stains were noted on the underside of resident #010's pillow case. The bed was made and all other linens appeared clean. The following day, the pillow case remained on the resident's pillow and was observed to have dried stains on both sides. Although, the identified day was not the resident's scheduled shower day, the pillowcase linen was not changed when it was stained, as it was observed on the bed two days in a row.

Interview with the FSS/Director of Housekeeping and Laundry confirmed that the residents' linen are to be changed once a week on bath days, and as needed. They also reported that the home had plenty of linens available and the pillow case of resident #010 should have been changed if stained. (528) [s. 89. (1) (a) (i)]

Issued on this 8th day of May, 2017

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

Original report signed by the inspector.