Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2019	2019_532590_0022	014036-19	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 at St. Clair
1800 Talbot Road WINDSOR ON N9H 0E3

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

ALICIA MARLATT (590)

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): July 31 and August 1, 2, 6, 7, 8 and 9, 2019.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Nursing, two Assistant Directors of Nursing, two Registered Practical Nurses, five Personal Support Workers, two Neighbourhood Coordinators and one family member.

During the course of the inspection, the inspector(s) reviewed one residents clinical record, one Infoline report, policies relevant to inspection items and email correspondence.

During the course of the inspection, the inspector(s) observed one resident for specific interventions to be in place, the general maintenance and cleanliness of the home, the posting of required information and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee had failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A complaint was received by the Ministry Of Long-Term Care (MOLTC) from the Substitute Decision Maker (SDM) of resident #001. The SDM reported concerns of the resident possibly not receiving nutritional interventions when they were not in the home. They shared that resident #001 often would refuse their meals and wanted the staff to offer them a supplement if they refused to eat.

A review of resident #001's care plan showed several interventions to be implemented if the resident refused to eat their meal, or ate poorly at a meal.

A review of resident #001's progress notes showed two notes related to the topic of supplement administration and when it was to be provided. One note on a specific date, was a care conference note with the family which documented that a supplement was ordered as needed for a poor appetite at lunch and dinner. The second note dated two days after the care conference, was documented by the Registered Dietitian (RD) and wrote that a supplement was ordered as needed and to offer it to the resident if they were refusing their meals.

A review of resident #001's electronic Medication Administration Record (eMAR) was completed for a three month time frame. The eMAR's showed an order which directed staff to provide a supplement as needed per family request. Those records showed that resident #001 was provided a supplement four times in the evening hours during the time frame reviewed.

A review of resident #001's Point Of Care (POC) meal intake records, eMAR and progress notes on the corresponding days when the resident was identified in POC as eating only 0-25 per cent of their meal and refusing their meal, was completed for a three month time frame. Those records showed the following:
- On a specific day, a progress note was written that the resident refused their lunch; there was no further documentation about a supplement being offered in this note. There was a supplement documented as provided in the evening.
- On a specific day, the POC showed that the resident ate only 0-25 per cent of their lunch meal. A progress note written documented that the resident was not feeling well and was offered fluids and fruit. On the eMAR there was no supplement documented as provided.
- On a specific day, the POC showed that the resident ate only 0-25 per cent of their meal at breakfast time. On the eMAR there was no supplement documented as provided.
- On a specific day, a progress note documented that the resident did not want to come to the dining room for the lunch meal and that lunch was saved for them, however there was no further documentation as to whether the saved lunch was consumed or if a supplement was offered. On the eMAR there was no supplement documented as provided.
- On a specific day, there was a progress note written that the resident refused all offers of lunch and that several attempts at offering lunch was made, however there was no documentation as to whether a supplement was offered. On the eMAR there was no supplement documented as provided.

In an interview with Director Of Nursing (DON) #101, they were asked about what the

SDM had communicated to them about the offers of a supplement when the resident refused their meal or ate poor. They said that the family had requested that if the resident refused their meal to offer foods brought in by themselves first and if they refused to eat that food, to offer a supplement and document the amount consumed. They confirmed that the eMAR directed staff to provide a supplement as needed per family request and that the family's request was not identified on the eMAR as to when to provide the supplement. They shared that because the eMAR directed the staff 'as requested by family' that the supplement would only be provided if the family was there to ask for the supplement. They shared that the resident was not a nutritional risk, as their weight was stable and their Body Mass Index was within range for the resident. We reviewed the progress notes together that were written at the care conference and by the RD. The DON shared that if the RD documented that the resident was to receive a supplement as a meal replacement when refusing meals, and that it was communicated to the family that the supplement would be offered if the resident ate poorly, that the eMAR should have been written more clear as to when to provide the supplement. [s. 6. (1) (c)]

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

A complaint was received by the MOLTC from the SDM of resident #001. They shared their concerns that the resident was not having a specific treatment applied on a daily basis as ordered by the physician. They shared that most times when they came to visit, a few times a week, they have observed the treatment not to be on the resident.

Review of resident #001's care plan showed that there was a treatment present which provided clear instructions to the registered staff to apply and remove the treatment daily. The care plan directed the staff to document when the resident refused the treatment.

Review of resident #001's progress notes, showed that staff documented that the SDM requested that the treatment be applied daily. Another note written a couple weeks later documented that the SDM expressed concerns that the treatment was not being applied by the staff and requested that only registered staff apply the treatment and to document refusals of the treatment in the progress notes.

In an interview with Registered Practical Nurse (RPN) #108 in the afternoon on a specific day, they observed with the inspector that resident #001 was not wearing their treatment and responded when questioned that they should be on as it was part of their plan of care.

Review of the eMAR for resident #001 showed that the treatment was signed for as applied on all four days of observation.

In an interview with DON #101 they shared that daily application of the treatment was part of resident #001's care plan and that staff were to document when the resident refused the treatment. They shared that they would be following up with the staff that completed the documentation that the treatment was applied on a specific day when an observation was made that the resident was not wearing the treatment in the afternoon. [s. 6. (7)]

3. The licensee had failed to ensure that the following were documented: 1. The provision of the care set out in the plan of care. 2. The outcomes of the care set out in the plan of care. 3. The effectiveness of the plan of care.

A complaint was received by the MOLTC from the SDM of resident #001. The SDM reported that they were concerned with documentation in the home, and felt that some care being provided was not documented and that some care documented was not provided. The complaint had multiple concerns and documentation was monitored throughout this inspection.

Review of resident #001's progress notes showed an entry documented on a specific day that the resident refused a meal and that a supplement was provided and consumed.

Review of the eMAR for the identified day, showed that there was no documentation about a supplement being provided and consumed by the resident.

The homes policy titled "Resident Care Documentation", policy number 08-06 and last reviewed on January 2, 2019, stated the following:
1) Documentation will include the assessment of the problem/issue, the support actions/treatments used or planned to be used, and the response of the support actions/treatment or resolution to the health concern being documented.
2) A good entry is thorough, with complete information about the resident, including all health concerns and/or nursing support actions and outcomes.
3) Document accurately and record each issue (depending on what it is this may be a progress note or require an assessment to be completed) in the current computerized software system.
4) Document during, or as soon after, the care/event as possible.

5) Signing of the MAR will be completed only when the medication has been administered to the resident as ordered by the physician.
6) All as needed medications given will be signed for with date/time and dosage. The date and hour of administration, writer's initials, name of medication and dose, the reason for administration, and outcome (i.e. effective or ineffective with response), must all be completed within the computerized software system.

In an interview with the DON #101, they shared that when a supplement was provided to any resident, that it was to be documented on the eMAR, and that the administration of the supplement was not documented by the staff on that specific day on the eMAR. [s. 6. (9) 1.]

4. The licensee had failed to ensure that if the resident was being reassessed and the plan of care was being revised because care set out in the plan has not been effective, have different approaches been considered in the revision of the plan of care.

A complaint was received by the MOLTC from the SDM of resident #001. The SDM shared that they were concerned with the behaviour management in the home. In a pre-inspection interview they shared that the resident was cognitively impaired, displayed responsive behaviours and could be challenging to care for. They shared that the resident had been in the home for some time now and thought the home should have developed strategies to assist the team to manage the behaviours and provide appropriate care that was required. They shared that the resident continued to refuse care at this time. They explained that the care area that was lacking as a result of the behaviours was general hygiene and continence care. The SDM shared that the physician had ordered medications that could be used for behaviour management as needed with their permission, however felt that the staff were not utilizing them.

Review of resident #001's medication list for a specific month, showed that the resident was taking several medications for behaviour management. There were medications that were regularly scheduled daily, medications ordered for when the resident was agitated throughout the day and for when care was to be provided:

In interviews with Personal Support Worker's (PSW) #105, 107 and 109 they all shared that resident #001 was a challenge to care for, in that they would often refuse the care offered and can get verbally and physically expressive when the staff re-approach them frequently. They reported that some staff members had been hurt by the resident while attempting to provide care. They shared that the resident's physical behaviours can be

triggered by the bathing process and during times of continence care. They share that the resident was usually agreeable and pleasant to go in for a shower, but would become physically aggressive when the staff attempted to assist them to undress for the shower and at times have had to end the bathing task so no one gets hurt. They all shared that they used a stop and go approach with the resident and that this intervention was not always effective in making the resident accept care.

Review of resident #001's eMAR's for a three month period showed that the as needed medication was not administered at all in one month, administered only twice in the second month reviewed and was not administered again in the third month reviewed.

In an interview with RPN #106 and 108 neither nurse mentioned the use of an as needed medication that could be used. Inspector asked RPN #106 about the as needed medication and the nurse stated that he was already on that medication which was scheduled twice a day, and that the family would sometimes refuse the use of the as needed medication regardless of the nurses assessments of the behaviours. They said that sometimes they do not attempt to administer the as needed medications for behaviours as it would be too close to the regularly scheduled times for administration.

In a Behaviour Supports Ontario (BSO) Assessment Follow-up Form prior to these care refusals, they recommended utilizing the as needed medication and noted that the nurse shared concerns with the administration times of the regularly scheduled medication in conjunction with the use of the as needed medication.

In a Mental Health Outpatient Consultation report, the following was written: It seems that the as needed medication has been utilized, although there was some disconnect between the patient's daughter's perception of how many times the as needed medication had been used and the actual number of as needed medication doses given. We spent time discussing the illness process and how behaviours changed, and also the fact that both medication and psychological intervention can be important. From the patient's daughter's standpoint, she felt that the medication had not worked, although seeing the doses prescribed and the utilization of the as needed medication, we felt that this was an avenue that could be explored further before we change this medication. The medication dose was increased and it was also ordered for one hour prior to care as needed.

In an interview with Executive Director (ED) #100, DON #101, Assistant Director of Nursing (ADON) #110 and Neighbourhood Coordinator (NC) #111 they stated that they

were aware of the families concern with behaviour management and care refusals. They shared that several interventions have been implemented to encourage the acceptance of care which included re-approaches, and calling the family for assistance. When asked about the use of the as needed medication they shared that communication from the SDM has been confusing up to this point in regards to when they want the as needed medication administered and requested that staff call for permission prior to giving the as needed medication. They shared that sometimes the staff would call the SDM for permission to give the as needed medication and that the family would often refuse to have the medication administered. When asked if those conversations where the SDM was refusing the medication intervention for behaviours should be documented in the progress notes they shared that perhaps it should be moving forward, but might not be there if I looked for any documentation at this time. They acknowledged that the as needed medication was not being utilized by staff as it could have been when the resident was refusing care. [s. 6. (11) (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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 48 (1) 4 stated that every licensee of a long-term care home shall ensure that the following interdisciplinary programs were developed and implemented in the home: A pain management program to identify pain in residents and monitor pain.

A complaint was received by the MOLTC from the SDM of resident #001. The SDM shared in a pre-inspection interview that the resident displayed responsive behaviours and could be challenging to care for. They shared that the resident does experience pain and felt that this contributed to the residents responsive behaviours. They further shared that they felt that the home was not addressing the residents pain appropriately, further contributing to the poor management of behaviours.

In an assessment note written by the Geriatric Mental Health Outreach Team on a specific day, they provided a clinical recommendation directing the staff to continue to monitor and treat pain as necessary as the resident had a history of broken bones according to the family.

Review of the completed assessments showed that a pain assessment was completed 16 days after the recommendation to monitor pain was provided.

Progress notes showed that on a specific day, a note was written that the SDM had spoken with the physician about the resident having pain and an order for an analgesic cream and warm compresses as needed was written. Review of the eMAR for that month showed that the resident was not provided any as needed analgesics that day and review of completed assessments showed that no pain assessments were completed that day when the SDM had reported the pain.

Review of the homes policy titled "Pain Management Program", policy number 04-48, last reviewed on April 24, 2019, stated the following:
That pain assessments using the homes pain assessment tool would be completed with the initiation of a pain medication or an as needed analgesic, when there were personal

expressions exhibited by resident that may be an indicator for the onset of pain, when reported by the resident, family, team member or volunteers that pain was present.

In an interview with DON #101 they shared that when a recommendation was provided by an external team they would usually provide a time frame or a length of time they wanted the assessments to be completed for and on that specific note, no length of time was identified. They shared that the initiation of recommendations might take a little while depending on when the home received the recommendations, as sometimes external reports took a couple days to get to the home. The DON stated that the homes Personal Expressions Response Team (PERT) usually implemented recommended interventions and that they have a large workload and may not have gotten to it right away. When asked if the staff should have just initiated the pain assessments on their own, they said that the staff should be monitoring for pain daily as we were taught in nursing school. When asked if a pain assessment should have been completed when the SDM reported that the resident was having pain and when the analgesic cream was ordered, the DON shared that they thought the pain policy specifically stated when pain medications were started that an assessment would be done and that the analgesic cream was more of a natural remedy. When asked if the analgesic cream was ordered for the purpose of providing pain relief the DON responded that it was ordered for that purpose and that a pain assessment should have been done. [s. 8. (1) (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 that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: 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 had failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A complaint was received by the MOLTC from the SDM of resident #001. They shared that the resident had an infection on their skin and that the staff did nothing about it after they reported it to them, and provided treatment after the second time they brought the skin concern to the staff's attention.

Review of resident #001's progress notes showed a note written on a specific day documenting that the SDM had brought forth a concern of a possible skin infection to the attention of a PSW a couple days before. The SDM reported that a nurse had been made aware of the concern but was not sure which nurse was notified. The note documented that the PSW had confirmed that they were aware of the impaired skin area a couple days before but there was no documentation about the impaired area of skin in the notes a couple days before when the note was written. The note further documented that a skin assessment was requested to be completed that night and if anything was observed to report it to the physician.

Review of resident #001's skin assessments showed that a skin assessment was not completed that day as requested, but was completed on the following day that the note was written. There were no documented skin assessments in the couple days prior to when the note was written, when the SDM shared that they had originally reported the issue.

There was a referral to the skin care lead staff member made on the same day the note was written which reported a skin concern, but provided no assessment information about the area of impaired skin integrity.

The progress notes on the same day the note was written, documented that a referral to the skin care lead was made and that the physician was contacted. The physician ordered a specimen to be taken and ordered specific treatment which started right away for the infected area of skin.

The homes policy titled "Skin and Wound Care Program", policy number 04-78 and last reviewed on August 6, 2019, stated that the PSW should recognize and report resident changes in skin comfort and reports and documents abnormal or unusual skin concerns to the registered nursing team member, including but not limited to red or open areas, blisters, bruises, tears, scratches. The policy further stated that "The registered team member will conduct an assessment and document that assessment: Complete a PRN Skin Assessment will be performed when there is a change in skin integrity and weekly thereafter until it is healed.".

In an interview with DON #101, they were unsure of when the area of impaired skin integrity was initially seen by the PSW, but thought it was the day before the note had been written. When asked if the PSW had reported this to the registered staff for follow up they said that they thought the PSW had not reported the concern immediately, and should have reported it to the registered staff when it was originally observed. The DON said that the home has an assessment tool designed for skin and wound and this assessment should have been completed when the area of concern was initially observed as per the home's policy. [s. 50. (2) (b) (i)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, 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 had 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 complaint was received by the MOLTC from the SDM of resident #001. The SDM reported in a pre-inspection interview that they were concerned with the resident not having regularly scheduled baths. The SDM shared that resident #001 displayed behaviours which made it difficult for the staff to provide care and acknowledged that the resident often would refuse their baths and personal hygiene care. The SDM shared that they were concerned with general hygiene and continence care at the home as they often came to visit and found the resident in soiled clothing.

Review of POC and progress note documentation for a two month period, showed baths offered and refused, along with the staff's re-approach attempts and interventions tried.

In interviews with PSW's #104, 105 and 109, they all shared that providing care to resident #001 was usually a challenge in that the resident was confused and there was a language barrier. They all shared that the resident would often refuse care and persistent and frequent re-approaches would agitate the resident. They all shared that when the resident displayed personal expressions the resident would become verbally and physically aggressive with staff. When the resident displayed these behaviours they said they were to use the stop and go approach, in that they were to leave the resident alone and attempt to provide the care again in a little while when the resident appeared calm again. They further shared that they frequently had to use the stop and go approach, and this approach was not always effective in making the resident accept care from them, but were to continue to approach the resident until the care required had been provided. This approach was used for the safety of all people involved, as the resident can get physical with staff when agitated. They shared that they had been instructed to document any care attempts made, along with the results of their attempts, if care was accepted or not. They all shared that their bathing documentation was completed in the POC system and they also verbally report to the registered staff whenever the resident continually refuses care so other interventions could be utilized.

Review of the homes' policy titled "Spa (Shower, Tub Bath, Sponge Bath)", policy number 04-06 and last revised on May 24, 2019, stated that "It is the policy of Schlegel Villages 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 (2) per week as per the resident's needs/requests.". The policy further stated that "When a resident declines their spa after multiple attempts and negotiation, it must be documented on the POC as a refusal and the PSW will report this refusal to the registered team member and the registered team member will document the reason for refusal and alternative interventions tried without success. If resident refuses today, offer their spa the following day, or later in the shift. The resident's family may be contacted for their input into alternative suggestions.".

In an interview with Assistant Director Of Nursing (ADON) #112 they shared that when a resident refused a bath, re-approaches were to be completed and if the resident continued to refuse, that the bath should be offered the next day and the next, until the bath had been accepted.

In an interview with ED #100 and NC #111 they shared that when a resident refused a bath, that the staff were to re-approach throughout the rest of the day to provide the bath. They shared that the bath should be offered the next day, but would depend on the

staffing level and their bathing schedule for that day. They shared that the bath should be offered if the regularly scheduled baths were completed and if there was enough staff working to complete it.

In an interview with DON #101, we reviewed the POC documentation and the progress notes for the identified dates of the bath refusals of resident #001. The DON confirmed that the resident did not have two baths a week for two weeks in two months in 2019. We also reviewed together the re-approaches completed by the staff and they acknowledged that there were no re-approaches made or documented for bathing on a specific day when the scheduled bath was refused by the resident. The DON shared that this resident often would refuse care and that several attempts were made daily to get the resident to bathe. The DON further shared that documentation supported that the staff had used interventions to encourage the resident to bathe, such as re-approaches and calling the family for assistance and that the resident continued to refuse. The DON acknowledged the legislation and the home's policy that required the licensee to provide two baths a week of the residents choice and that two baths a week had not been performed for resident #001. [s. 33. (1)]

WN #5: 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 had failed to ensure that the resident received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A complaint was received by the MOLTC from the SDM of resident #001. The SDM shared in a pre-inspection interview that they were concerned with nail care not being provided in the home. They shared that they have found the resident's toenails to be long, curled over at times and chipped, increasing the risk for infection. They shared that they also found at times that the resident's fingernails were not cleaned properly either.

The SDM was able to provide some pictures of the resident's fingernails and toenails to the inspector.

Observations of the resident's fingernails were completed once daily over a four day period from August 6 to August 9, 2019. The inspector found the resident's fingernails to be trimmed appropriately, and there was a small amount of debris observed under the resident's nails. No observations of the resident's toenails could be made.

A review of progress notes showed a note written on a specific day documenting concerns from the SDM about lack of toenail care. The writer of the note was called to the spa room by the SDM during care for resident #001 where they documented that they observed the resident's toenails to be “very long, curled under with some chipped”. The writer checked back for a two week period on the PCA (Personal Care Attendance) reports and noted that the resident's nails had been cleaned but not trimmed.

In an interview with PSW #109 they shared that nail care was usually done on bath days and that they were supposed to trim and clean under every resident's nails and document the care in POC. They shared that nail care can be difficult to provide to resident #001 due to their refusals of care and unpredictable physical personal expressions. They further shared that any care refusals were supposed to be documented in POC.

Review of the policy titled “Spa (Shower, Tub Bath, Sponge Bath) policy number 04-06 last reviewed on May 24, 2019, directs staff that after bathing is completed, provide nail care to feet and hands. The policy stated that if the resident refused their spa after multiple attempts and negotiation, it must be documented on the POC as a refusal and the PSW will report this refusal to the registered team member and the registered team member will document the reason for refusal and alternative interventions tried without success. Further the policy stated that if the resident refuses today, offer their spa the following day, or later in the shift.

In an interview with DON #101 they shared that nail care was supposed to be completed on bath days and that nail care at the home included the trimming and cleaning of finger and toenails. The DON was unable to provide any PCA reports for the inspection or speak to the issue identified. [s. 35. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee had failed to ensure that each resident received the assistance required to dress and was dressed appropriately, suitable to the time of day and in accordance with their preferences, in their own clean clothing and appropriate clean footwear.

A complaint was received by the MOLTC from the SDM of resident #001. The SDM shared in a pre-inspection interview that they felt the homes staff lacked communication amongst themselves, especially regarding laundry issues. They shared that the resident had to wear pyjamas during the daytime hours because the staff did not follow their instructions regarding laundry care. The SDM shared that they take the resident's soiled laundry home to launder themselves as the home has ruined clothing before. The SDM said that the resident has always taken pride in their appearance and never wore pyjamas during the day prior to moving into the home.

Review of resident #001's progress notes showed a note written on a specific day where staff documented that there were no clean pants for the resident and they had contacted the SDM to ask if they could bring in more clothing for the resident. The note documented that the SDM informed the staff to launder two pairs of pants at the home because they could not attend the home that day, they also directed the staff to contact another SDM to see if they could help with a shower and care. The staff had contacted the other SDM who also was unable to attend the home that day.

There were two progress notes written on the following day. The first note written at 1259 hours documented that the SDM had been notified that the resident had no clean pants available, and the second note written at 1300 hours documented that the resident was showered today but was dressed in pyjama pants as they had no clean pants available.

In an interview with DON #101 they shared that the direct care staff can launder clothing and would be expected to if a resident or their SDM requested the service. The DON acknowledged that resident #001 took pride in their appearance and that the residents preferences for their appearance of being dressed in daytime clothing was not accommodated in this situation. [s. 40.]

Issued on this 5th day of September, 2019

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

Original report signed by the inspector.