Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 24, 30, Feb 8, 9, 10, 13, 14, 15, 17, 22, Apr 24, May 9, 2012	2012_027192_0002	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

RIVERSIDE GLEN LONG TERM CARE FACILITY
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'Inspection

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

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers, Dietitian, Registered Practical Nurses, Registered Nurses, Director of Nursing Care, Assistant Director of Nursing Care, Assistant General Manager, and the Director of Environmental Services related to H-002331-11, H-000073-12, H-000143-12, H-001437-11, H-001710-11, H-002194-11, H-00008-12(H-002504-11), H-002258-11, H-002394-11 and H-000269-12.

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, policy and procedure and observed care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Accommodation Services - Maintenance

Continence Care and Bowel Management

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. [r. 101. (1) 1.]

During interview with the Director of Environmental Services it is identified that verbal complaints related to laundry and personal items are not recorded and a response is not provided within 10 business days of receipt of the complaint. No record of complaints related to laundry are kept in the home even though the Director of Environmental Services confirms that the home has a problem with missing laundry.

A complainant verbally addressed concerns with the home on three occasions related to the frequency of bathing and cleanliness of a resident's denture cup. In 2012 two telephone messages were left for the Director of Care related to these concerns. The home was unable to provide documentation confirming communication with this complainant, action taken or a response to the complainant.

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 ensuring that every written or verbal compliant made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as set out in section 101 O.Reg. 79/10 s.101, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

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 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. [r. 33. (1)]

Three of three residents reviewed did not consistently receive baths twice weekly as their plan of care indicates is required. Interview with staff and management confirm that the bath nurse is pulled from their duties when the home is unable to replace a call-in on a neighborhood within the home and that this can result in bathing not being completed. The home does not consistently schedule additional staff to complete the baths missed when staff shortages occur and regular staff working the home area are not consistently able to complete the bathing scheduled.

A specified resident is not consistently bathed twice each week as indicated in the plan of care. Documentation indicates that the resident received no baths in November and received a bath or shower only on specified dates in 2012. Interview with staff confirms that the resident does refuse a bath, related to a belief that they are capable of managing their own care. Staff interviewed identified that specific staff are successful in encouraging the resident to bathe and that staff who are unfamiliar to the resident will result in the resident refusing care. No interventions are identified in the plan of care to ensure that the resident receives her bath, in spite of staff on the home area being aware of how to manage the resident's needs.

A specified resident's plan of care indicates physical help with part of bathing activity - 1 staff to assist. Prefers to have a tub bath twice weekly as per bathing schedule. Bathing is not consistently provided twice weekly as confirmed by documentation review and interview. No bath was documented to have been received on specified dates in 2011 and 2012.

A specified resident is identified in the plan of care to require total assistance for bathing twice weekly. Documentation review and interview with resident and staff confirm that the resident does not consistently receive a bath twice weekly. The resident is at high risk for altered skin integrity related to a history of pressure related skin breakdown.

Staff interviewed indicated that there is not consistently staff available to provide baths to residents of the home. A bath nurse is to be scheduled daily, but is frequently (5-6 times/month) re-assigned to cover call-ins on other home neighborhoods. This is confirmed during interview with the Neighbourhood Coordinator who indicated that staff on the home area try to complete some of the baths, but baths may be missed as a result of re-assigning the Bath Nurse.

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 ensuring 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 #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 subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. [r. 50. (2) (b) (iv)]

A specified resident was reported by the Personal Support Workers to have sustained specified areas of altered skin integrity in 2011 and 2012.

There is documentation that these areas were identified by Personal Support Workers and treatment was initiated. Documentation and interview confirm that no weekly re-assessments have been completed by the registered nursing staff, related to these identified areas of altered skin integrity. Interview with registered staff identified that weekly assessments are only conducted on pressure related stageable wounds and not all areas of altered skin integrity.

Documentation review and interview confirm that a specified resident sustained specified areas of altered skin integrity in 2011. Treatments were initiated for these areas of altered skin integrity. Interview and documentation review confirm that weekly assessment by a member of the registered staff was not completed for these areas of altered skin integrity.

2. The licensee 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 is specifically designed for skin and wound assessment. [r. 50. (2) (b) (i)]

A specified resident sustained designated areas of altered skin integrity in 2011 and 2012.

No skin assessments were completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment as confirmed by documentation review and staff interview.

Documentation review and interview confirm that a specified resident returned from hospital in 2011 with a specified area of altered skin integrity. No assessment of this area of altered skin integrity was completed and documented until the following month in 2011 when the wound was identified to have increased in size.

On a specified date in 2011 it was noted that a specified resident had a specified area of altered skin integrity - no assessment was completed. On a specified date in 2011 a dressing was removed and it was noted that a Stageable area of altered skin integrity was present. No assessment of an area of altered skin integrity was recorded prior to the specified 2011 assessment. On a specified date in 2011 a specified resident was identified to have an area of altered skin integrity - no assessment was completed by a member of the registered nursing staff.

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 ensuring 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; is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #4: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is
complied with. [r. 8. (1)]

The homes policy titled Wound/Skin Care and dated January 2011 indicates that:

4. On an ongoing basis, the Personal Care Aid (PCA) will complete the skin assessment on each bath day and record on the PCA flow sheets if no concerns need to be addressed. If there is a concern, it will be documented using the Twice-Weekly Skin Assessment form and the Skin Assessment Concerns form will be completed and given to the Team Leader.

Documentation indicates that a specified resident did not consistently receive twice weekly skin assessments. No assessment is recorded on specified dates in 2011 and 2012.

Documentation indicates that a specified resident did not consistently receive twice weekly skin assessments. No assessment is recorded for specified dates in 2012.

9. The QI/Wound Care Nurse will complete the Wound Assessment Tool of the areas reported which will continue to be completed on a weekly basis by the Team Leader in the Neighborhood. The QI/Wound Care Nurse will continue to be responsible for completing the Wound Assessment Tool weekly for any resident on high intensity.

a) A specified resident was identified to have an area of altered skin integrity in 2011, on return from hospital the Wound Assessment Tool was not initiated for 5 weeks in 2011.
Documentation review and interview confirm that Personal Support Workers reported altered skin integrity for the resident on specified dates in 2011. Treatments were initiated for these areas of altered skin integrity. Interview and documentation review confirm that weekly assessment by a member of the registered staff was not completed for these areas of altered skin integrity.

b) Areas of altered skin integrity are not consistently reassessed once identified for a specified resident. On a specified date in 2012 an area of altered skin integrity was identified on the resident - no reassessment has been completed. On a specified date in 2012 the resident was identified to have another area of altered skin integrity - no reassessment was completed.

c) A specified resident sustained an injury in 2011 that was not assessed weekly, and an area of altered skin integrity that was not assessed weekly by a member of the registered staff.

12. The Team Leader will contact the Physician for orders specific to the wound needs. A referral to the Registered Dietitian will be completed for assessment of nutritional risk relating to skin integrity. The POA/Substitue Decision Maker will be informed.

A specified resident was identified to have areas of altered skin integrity on return from hospital. Dietary referral related the resident's skin condition did not occur for two months in 2011 at which time the area of altered skin integrity has worsened.
There is no record of the resident's family being notified of changes in skin condition on return from hospital; after specified reports of altered skin integrity. Interview with the registered nursing staff and the QI/Wound Care Nurse confirm communication with family would be recorded in the progress notes.

15. When efforts are not working within a reasonable length of time (e.g. 1-2 weeks), the resident will be referred to an Enterostomal and Wound Management Consultant. Fax referral must be completed and sent upon receiving the physician's order.

A specified resident was not referred to an Enterostomal and Wound Management Consultant for a four month period related to progressing areas of altered skin integrity. The specified resident was seen by the consultant on a specified date in 2011.

The homes policy Resident/Family Concerns requires that:
1. If a family or resident expresses a concern to a team member, the team member will notify the Department Manager in writing by way of an incident report form, providing as much detail about the nature of the complaint as possible.

The home was asked to provide, documentation to support this practice, but was unable, indicating that the incident form is not used to communicate complaints to the Department Manager.

8. The Department Manager will carefully document all discussions with families and results of investigations using the attached form. The General Manager will review the form and place one copy in the resident's file and one copy in the Resident Concerns binder in the General Manager's office.

Interview confirms that no form is used for documenting discussions with family. There is no Resident Concerns binder maintained within the home.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

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;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a process to report and locate residents' lost clothing and personal items. [r. 89. (1) (a) (iv)]

The Director of Environmental Services, was interviewed and identified that nursing staff who were made aware of missing clothing, would direct family members to the binder located at the reception desk on the main level, where the lost item would be recorded by the family member. The binder would be checked every few weeks or so by the Director of Environmental Services and a search would be initiated for the lost item.

The process identified is not complied with as evidenced by:
a) At the time of this inspection the binder in which lost items are to be recorded is missing and has been for some time.

b) Nursing staff interviewed identified the process for reporting lost clothing and personal items to be; family or the Personal Support Workers would notify the registered staff when an item was missing, who would notify the neighborhood coordinator and a search would be initiated of the lost and found.

A lost and found for unlabeled clothing is maintained, but is not labeled for easy identification by staff or family members.

It is evident that the current process to report and locate residents' lost clothing and personal items is not clear between departments in the home and therefore compromises its effectiveness for resident's and family members reporting lost clothing and personal items.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that written procedures comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. [s. 21]

The homes policy "Resident/Family Concerns" dated December 2010 does not include:

For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgment of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances as outlined in O. Reg 79/10 s. 101(1)(2).

WN #7: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

A specified resident is identified in the plan of care to require physical help with part of bathing activity, 1 staff to assist with washing her hair and back. Prefers to have tub baths 2 x weekly as per bathing schedule. During interview and documentation review it is identified that the resident frequently refuses bathing. No interventions are identified under bathing or behaviours that provide direction to staff in the event that the resident refuses a bath. Staff interview indicates that specific staff on the home area are able to be successful in convincing the resident to have a bath and that if the Personal Support Worker is not familiar to resident they will refuse care. The plan of care does not provide clear direction to staff and others related to bathing.

Issued on this 10th day of May, 2012

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

Deborah Saville (192)