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
Direction de l'amélioration de la performance et de la conformité

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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
Sep 16, 19, 20, 21, 22, 23, Nov 28, Dec 7, 8, 9, 12, 2011	2011_053122_0015	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
55 Standish Court, 8th Floor, MISSISSAUGA, ON, L5R-4B2

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

THUNDER BAY INTERIM LONG-TERM CARE CENTRE
445 SOUTH JAMES STREET, THUNDER BAY, ON, P7E-2V6

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

ROSE-MARIE FARWELL (122)

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 the Administrator, Director of Care (DOC), the Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), residents of the home and family members.

During the course of the inspection, the inspector(s) observed the provision of care and services to the residents of the home, reviewed resident health care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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. A resident wears a pull up brief as confirmed by a PSW and RN.

The resident confirmed that they wore a pull up brief with an extra pad in the daytime and a brief at night "because that's what I did at home". The resident reported that they supplied their own incontinence products .

The resident's Admission/Quarterly Continence Assessment completed on September 3, 2010 identified that the resident wears a brief only.

On September 19, 2011 the Inspector reviewed the Tena list located in the clean utility room of a resident care unit. The list identified the incontinence product needs of each resident on the unit. A heading for "Pull Up Brief" was not observed on the list.

The resident's continence plan of care completed on July 13, 2011 indicates that "the resident uses a large brief". The plan of care did not provide direction regarding the use of a pull up brief in the daytime as per the resident's stated daytime routine or preference.

The licensee failed to ensure that the written plan of care for the resident sets out clear directions to staff and others who provide direct care to the resident.

[LTCHA 20007, S.O., c. 8, s. 6 (1) c].

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 with LTCHA 20007, S.O., c. 8, s. 6 (1) c to ensure that there is a written plan of care for each resident that sets 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. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. On September 20, 2011 at 11:32 hrs, the Inspector observed a resident sitting in their wheelchair and propelling themself down the hallway of a resident care unit. The resident was observed to have a significant amount of facial stubble.

The MDS assessment completed on September 13, 2011, identified that the resident has short and long term memory deficits, moderately impaired cognitive skills for daily decision making and requires the extensive assistance of 1 staff member with ADLs related to personal hygiene, including shaving.

The plan of care was initiated on September 14, 2011, but was not yet completed. The plan of care identified that the resident requires extensive assistance with personal hygiene and that "the resident is able to assist in part of their care by using a basin and washing their hands and face."

A PSW assigned to provide care to this resident was interviewed. The PSW reported that the resident requires "total care" and added the resident would be shaved on their scheduled bath days. The PSW assigned to provide care to this resident was unaware of their scheduled bath days and consulted a second PSW who reported that the resident's scheduled bath days were Tuesday evenings and Friday day shift.

The Inspector interviewed a third PSW regarding the hygienic care and shaving needs of this resident and two other residents on the care unit. The PSW reported "they refuse a lot...our shavers are not the sharpest". "They let us do them once a week if we're lucky".

On Wednesday, September 21, 2011 at 10:12 hrs, the Inspector observed the resident with a significant amount of facial stubble. The resident remained unshaven despite their scheduled bath the evening prior.

The licensee failed to ensure that the resident received individualized personal care, including hygiene care and grooming, on a daily basis. [LTCHA 2007, O. Reg. 79/10, s. 32].

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2. On September 20, 2011 at 1132 hrs a resident was observed in the TV room of their respective care unit. The Inspector observed stubble on the resident's upper lip and chin. The resident was interviewed and reported that staff shaved their facial hair.

This resident's MDS assessment, initiated on July 17, 2011, was reviewed and identified that the resident has short and long term memory deficit, modified independence in daily decision making and requires the extensive assistance of 1 staff member for personal hygiene, including shaving.

The plan of care completed on August 12, 2011, identified that the resident requires the assistance of 1 staff for personal hygiene, including shaving.

A PSW was interviewed on September 20, 2011 regarding this resident's ADLs. The PSW reported "some days the resident is a 1 person assist, some days a 2 person assist with ADLs and personal hygiene". The resident was present in the room during the interview and reported that they shaved with an electric razor "once in a while", and "staff do it the other times."

The licensee failed to ensure that the resident received individualized personal care, including hygiene care and grooming, on a daily basis. [LTCHA 2007, O. Reg. 79/10, s. 32].

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3. On September 20, 2011, the Inspector observed a resident with stubble on their cheeks and chin. The resident was interviewed and reported self shaving with an electric razor.

On September 21, 2011, the Inspector observed that this resident's facial stubble remained unshaven from the previous

day.

The resident's MDS assessment completed on August 23, 2011, identified a diagnosis of dementia and arthritis, short and long term memory deficits, moderately impaired cognitive skills for daily decision making, the resident is easily distracted and requires the limited assistance of 1 person for hygiene, including shaving.

The plan of care completed on September 1, 2011, identified that the resident required overall supervision with ADLs and directed staff to "place shaver in resident's hand and position in front of mirror."

A PSW who identified that they were assigned to the resident's home area was interviewed regarding the resident's hygiene and shaving needs. The PSW denied recollection of ever providing am care to the resident and stated that they had "never even given the resident a bath but added that "everybody gets shaved on their bath days."

The PSW consulted a second PSW for clarification of the resident's personal hygiene and shaving needs. The second PSW reported that the resident "only gets shaved when in the bath", is "constantly walking and walking and walking" and added that the resident would get shaved if "you could catch them in their room in the morning."

The licensee failed to ensure that the resident received individualized personal care, including hygiene care and grooming, on a daily basis. [LTCHA 2007, O. Reg. 79/10, s. 32].

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 with LTCHA 2007, O. Reg. 79/10, s.32 every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following subsections:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On September 19, 2011, the Inspector noted the following personal items:

Two unlabelled tooth brushes and one unlabelled hairbrush were observed lying on top of the vanity in a resident's room.

One unlabelled denture cup was observed lying on top of the vanity in a resident's room.

One unlabelled tooth brush was observed lying on top of the paper towel dispenser in a resident's room.

The licensee failed to ensure that each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items. [LTCHA 2007, O. Reg. 79/10, s. 37 (1) a].

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 with O. Reg. 79/10, s. 37 (1)a

Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,

(a) labelled within 48 hours of admission and of acquiring, in the case of new items;, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On September 19, 2011 the Inspector observed that the foot rest and foot support of a resident's wheelchair were soiled with food crumbs and dirt.

On September 19, 2011 the Inspector observed a resident's wheelchair was heavily soiled with dirt.

On September 19, 2011 the Inspector observed that the base of the Sara lift located outside a resident's room was soiled with dirt.

The licensee failed to ensure that procedures are implemented for the cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids. [LTCHA 2007, O. Reg. 79/10, s. 87 (2) b].

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 subsections:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;
(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;
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;
(e) continence care products are not used as an alternative to providing assistance to a person to toilet;
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. A PSW, an RN and a resident were interviewed by the Inspector on September 19, 2011.

The PSW reported that the licensee had "temporarily" supplied pull up briefs in the past but does not do so anymore.

The RN reported that there were residents of the home who had difficulty with the tabs on the Tena briefs and who benefit from wearing a pull up brief. The RN added that if a resident is identified as potentially benefiting from the use of a pull up brief, staff are directed to contact the resident's family and request that they supply the continence care product.

The resident confirmed that they wore a pull up brief with an extra pad during the daytime and reported that they supplied these continence care products.

The licensee failed to ensure a range of continence care products were available and accessible to residents and staff at all times, in sufficient quantities for all required changes. [LTCHA 2007, O. Reg. 79/10, s. 51 (2) f].

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 with LTCHA 2007, O. Reg. 79/10, s. 51 (f), (g), (h), (i), (j) to ensure:

(i)a range of continence care products were available and accessible to residents and staff at all times, in sufficient quantities for all required changes.
(ii) to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable

(iii) to ensure that residents are provided with a range of continence care products that, are based on their individual assessed needs, properly fit the residents, promote resident comfort, ease of use, dignity and good skin integrity, promote continued independence wherever possible
(iv) to ensure that the continence products are appropriate for the time of day, and for the individual resident's type of incontinence., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On September 19, 2011 at 15:22 hrs a resident was sitting in a recliner chair located in the TV area of their respective care unit. The resident was observed asleep in the chair with a seat belt applied around their waist for safety; however, the resident was slumped and hanging over the right side of the recliner chair.

The resident's MDS assessment completed on September 7, 2011 identified that the resident requires a 2 person physical assist with transfers and repositioning.

On September 20, 2011 at 10:26 hrs, the same resident was seated in a wheelchair in the TV area of their respective care unit. The Inspector observed that the resident's face was smeared with a dried white substance which had not been wiped after mid morning nourishment.

The resident's MDS assessment; completed on September 7, 2011, identified that the resident requires varying degrees of assistance with all ADLs and specifically requires a 1 person physical assist with eating.

The licensee failed to ensure that the resident was properly sheltered, groomed and cared for in a manner consistent with their needs.
[LTCHA 2007, S. O., c. 8, s. 3. (1) 4].

Issued on this 5th day of January, 2012

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