Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2013	2013_168202_0004	T-2079-12	Complaint

Licensee/Titulaire de permis

SPECIALTY CARE INC
400 Applewood Crescent, Suite 110, VAUGHAN, ON, L4K-0C3

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

BLOOMINGTON COVE
13621 Ninth Line, Stouffville, ON, L4A-7X3

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

VALERIE JOHNSTON (202)

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): January 04, 07, 08, 09, 10, 11, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director of Care, Nurse Practitioner, Registered Nursing Staff, Maintenance/Handyman, Personal Support Workers, Housekeeping Staff

During the course of the inspection, the inspector(s) observed the provision of care to residents, clinical record review, Pest Control Records, home's policies related to Skin and Wound, Fall Prevention

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Falls Prevention

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s.6(7)]

Staff interviews and clinical record review revealed that resident #001 requires two staff assistance for all transfers, is at high risk for falls and will get up from bed unassisted. An interview with an identified Registered Nurse (RN) revealed that the POA for resident #001 requested a bed alarm be put in place while resident #001 is in bed and floor mat be placed on floor should he/she try to get up from bed. The RN indicated in an interview that the request for a bed alarm was reported on admission to the Assistant Director of Care and documented the request in the progress notes. On an identified day in 2012 during AM care, resident #001 was found with injuries and had complained of pain for two days. On day two, resident #001 was unable to weight bear and was sent to hospital as requested by the POA, requiring medical intervention.
An interview with the Director of Care confirmed that resident #001 was not provided a sensor pad bed alarm on admission as specified in the plan. [s. 6. (7)]
2. Resident #003's written plan of care directs staff to provide a two handled cup for fluid and soup during meals and provide frequent encouragement and or physical assist throughout the meal. During the course of this inspection, the following observations were made:
Resident #003 was provided a regular cup for water and one-handled cup for tea/coffee and was observed to be spilling his/her fluids on self which resulted in a large puddle of fluid beneath his/her wheelchair at breakfast.
Resident #003 was provided a two handled cup for soup and one regular cup for milk and was observed to be spilling milk while drinking and was not provided physical assistance with his/her meal at lunch as required in the plan of care.
Resident #005's written plan of care directs staff to provide a two handled cup for soup and fluids, supervision and cueing during meals. Resident #005 was provided a two handled cup for milk and a regular cup for water and was observed to be attempting to feed self while spilling water on clothes and pouring milk on the floor.
Resident #005 was provided regular cups (no handles) for all breakfast fluids including apple juice and cereal and was observed to be spilling the cereal on self and was not provided assistance or cueing from staff as required in the plan of care.
Resident #006's written plan of care directs staff to provide oversight, encouragement and cueing for eating. Resident #006 was observed to be in the dining with 1/2 glass of juice and 1/2 bowl of dessert on table and 1/4 of a sandwich on the floor with no staff present. [s. 6.(7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the 24-hour admission care plan based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co-ordinator. [s.24.(4)].

Clinical placement records for resident #001 indicate that this resident is at risk for injury with documented episodes of harm. Staff interviews and clinical record review revealed that resident #001 requires two staff assistance for all transfers, is at high risk for falls and will get up from bed unassisted. The POA requested that a bed alarm be put in place while resident is in bed and floor mat be placed on floor should he/she try to get up from bed unassisted.
On an identified day in 2012 during AM care, resident #001 was found with injuries and had complained of pain for two days. On day two, resident #001 was unable to weight bear and was sent to hospital as requested by the POA, requiring medical intervention.
An interview with the Director of Care (DOC) confirmed that resident #001 was not provided a sensor pad bed alarm on an identified day in 2012. [s. 24.(4)]

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 care set out in the 24-hour admission care plan is based on the resident's assessed needs and preferences and on the assessments, reassessments and information provided by the placement co -ordinator, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program are readily available at the home. [s.49.(3)]

Clinical record review revealed that resident #001 is at high risk for falls and will get up from bed unassisted. An interview with an identified Registered Nurse (RN) revealed in an interview that the POA requested a bed alarm be put in place while resident is in bed should he/she self ambulate from bed.
An interview with the Director of Care confirmed that resident #001 was not provided a sensor pad bed alarm on admission as specified in the plan of care. The Director of care indicated in an interview that during the admission all the sensor bed pads in the home were used by other residents and there were none available. [s. 49. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that equipment, supplies, devices and assistive aids for the fall prevention and management program are readily available at the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. [s.30. (2)]

Clinical record review identifies resident #001 as having altered skin integrity requiring turning and repositioning every 2 hours. Interviews with direct care staff revealed that resident #001 is to be repositioned every 2 hours, however the time of which he/she was last repositioned could not be confirmed. Interviews with registered staff confirmed that there is no documentation completed related to residents that require repositioning every two hours. The registered staff confirmed that it is the responsibility of the personal support workers to communicate repositioning frequency.

A review of resident #003's clinical records revealed that this resident had been identified with altered skin integrity. A review of resident #003's clinical records revealed that there is no documentation of assessment for resident #003's altered skin integrity . [s. 30. (2)]

WN #5: 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 failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive 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. [s. 50. (2) (b)(i)]

A review of the progress notes for resident #003 revealed that on an identified day in 2012, a personal support worker reported that resident #003 had altered skin integrity. Clinical record review and staff interviews revealed that resident #003 did not receive 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. [s. 50. (2) (b) (i)]

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Issued on this 5th day of March, 2013

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