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
Jun 25, 2014	2014_242171_0010	L-000643-14	Resident Quality Inspection

Licensee/Titulaire de permis

BLUEWATER REST HOME INC.
37792 Zurich-Hensall Rd, RR #3, ZURICH, ON, N0M-2T0

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

BLUE WATER REST HOME
LOT 21, HWY 84, R. R. #3, ZURICH, ON, N0M-2T0

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

ELISA AGNELLI (171), CHRISTINE MCCARTHY (588), RHONDA KUKOLY (213), SALLY ASHBY (520)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 9-13 and 16, 2014

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care, Resident Assessment Instrument (RAI) Coordinator, Environmental Services Manager, Food Services Manager, Registered Dietitian, Therapy Services Coordinator, Pharmacist, 2 Registered Nurses, 3 Registered Practical Nurses, Cook, 3 Dietary Aides, Housekeeper, 7 Personal Support Workers, Family members and Residents.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed health records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
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 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. (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).

Findings/Faits saillants :

1. The licensee failed to ensure the written plan of care set out clear direction to staff.

An identified resident was observed using a specific mobility device during this inspection. A review of the Minimum Data Set (MDS) section of the plan of care indicated this device was used, however the kardex and point of care information that is accessible to the Personal Support Workers (PSWs) did not include it.

Registered staff confirmed this device was not included in the care plan or kardex and the expectation that it should be included to provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

a) The nutritional plan of care for an identified resident included an order for a specific item three times a day with medications and extra if the resident ate less than 50% of the meal.

The meal intake records in Point of Care indicated the resident took less than 50% of meals on many occasions over the course of a week.

Documentation is noted relating to intake of the item with medications, however there is no documentation of any additional being given on the dates when the resident's intake was less than 50%. (588)

b) The nutritional plans of care for two other residents included orders for a specific item three times a day with medications and extra if the resident refused to eat the main entrée.

The meal intake records indicated both residents refused a number of meals within one week.

Documentation is noted relating to the item given with medications, however there is no documentation found in the plan of care to indicate the item was provided on the dates when meals were refused.

The Director of Care (DOC) confirmed there was no separate documentation to show the item was provided as per the plan of care on the days the meals were refused.

The DOC confirmed the expectation that documentation of the provision of this item occurs in every instance it is provided. [s. 6. (9) 1.]

3. The licensee failed to ensure the provision of care set out in the plan of care was documented.

A review of the food intake records for two identified residents revealed missing documentation regarding meal intake.

Food intake is recorded in Point of Care and there are options that can be chosen to indicate a resident refused a meal or was not available at meal time, however there were instances where no documentation occurred.

The first resident was missing documentation for 5 meals in a one week period.

The second resident was missing documentation for 4 meals in a one week period.

Both residents were assessed at high nutritional risk.

The Director of Care confirmed the expectation that documentation of the provision of meals occur for all 3 meals every day. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure clear direction is provided in the written plan of care and that the provision of care is documented, 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) The home's Falls Management and Prevention Policy NRSG_5_1 includes the requirement that a Post Falls Assessment Huddle be completed on Point Click Care (PCC) when a resident has had three falls within one calendar month.

No Post Falls Assessment Huddle was found on Point Click Care for an identified resident. An interview with the Director of Care (DOC) verified there was no post fall assessment huddle completed for this resident after three falls, which is not compliant with their policy. (520)

b) The home's procedure for the Narcotic Count sheet and Controlled Medication Count sheet included staff recording the count and their initials at the bottom of the sheet when coming on and going off duty.

Missing initials from the nurse going off duty were noted on both the Narcotic Count Sheet and the Controlled Medication Count Sheet for June 4, 2014.

The DOC confirmed the expectation that each column on the two sheets should be initialled by the nurses. (520)

c) The home's procedure for documenting the Vaccination Fridge Daily Temperatures included staff recording the time and temperature and initialling twice per day.

This information was missing on the following dates: January 8 (a.m.), January 24 (p.m.), February 1 (p.m.), February 2 (a.m.), February 21 (p.m.), February 23 (a.m.), February 26 (p.m.), March 2 (p.m.), March 5 (p.m.), March 11 (p.m.), March 12 (p.m.), March 20 (p.m.), March 21 (p.m.), March 22 (p.m.), April 6 (p.m.), April 12 (p.m.), April 22 (a.m.), May 16 (p.m.), June 10 (p.m.).

The DOC confirmed the missing documentation and verified the expectation of the home is to have complete documentation. (520)

d) The home's policy "Resident Dining Atmosphere" included the following procedure: Order of meal service is rotated so that all Residents have the opportunity to be served first.

There was no indication of a set rotation of meal service at the lunch meals observed on June 9 and 12, 2014.

Dietary staff and the Food Services Manager confirmed that there is not a formal meal service rotation to ensure all residents have the opportunity to be served first. [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 policies and procedures regarding Falls Management and Medications are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee had not ensured transferring and positioning devices were safe when used to assist residents.

Observations revealed that transfer devices were being used in three resident rooms. The transfer devices were unsafe for use as they were loose, therefore did not provide support for the resident.

The CEO and Environmental Services Manager confirmed these transfer devices were not safe for the resident to use and they were removed. (213)(520) [s. 36.]

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 staff use safe transferring and positioning devices when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

Observations at a lunch meal service revealed a resident was served soup 10 minutes before assistance was available. Observations on another day's lunch meal service revealed three residents were served soup 13 minutes before assistance was available.

The Food Services Manager confirmed it was the current practice to serve soup before assistance was available. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a meal is not served until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee shall ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On June 9, 2014 in the Sunset Home Area an unlocked and unattended housekeeping cart was noted. The Inspector was able to access chemicals such as Real N' Odour through the unlocked door. A housekeeper verified the cart was unlocked and stated the expectation of the home is to have a locked cart. [s. 91.]

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 all hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The Licensee failed to ensure that the home is maintained at a minimum of 22 degrees Celsius.

On June 16, 2014 at 1130 the Inspector noted the following temperatures in resident's rooms: 21.0, 20.5 and 21.5 degrees Celsius.

Temperatures were verified by a registered staff member at 1145.

On June 16, 2014 at 1330 during a walk-through with the Environmental Services Manager the following temperatures were noted: Sunset Home Area Dining Room was 21.0 degrees and an resident room was 19.0 degrees Celsius.

Temperatures were verified by the Environmental Services Manager. [s. 21.]

WN #7: 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 not ensured that any resident exhibiting altered skin integrity, including skin tears 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.

A review of the progress notes for an identified resident revealed a note that the resident had a new skin tear. There were no further notes regarding this incident. There was no documented assessment in the Risk Management section of Point Click Care and no other assessments found using a clinically appropriate assessment instrument. Registered staff interviewed indicated there were no lasting marks the following day, however this was not documented in the medical record.

Registered staff confirmed there was no documented skin assessment using a clinically appropriate assessment instrument of this incident. [s. 50. (2) (b) (i)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a process to report and locate residents' lost clothing and personal items.

During interviews with residents it was noted that there were at least three instances of laundry going missing. In review of the home's laundry policies and procedures it was noted there was not a formal process to report and locate residents' lost clothing.

The CEO and the Environmental Services Manager confirmed that there was not a process to report and locate residents' lost clothing and personal items. [s. 89. (1) (a) (iv)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (4) Where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:
1. The date of removal of the drug from the drug storage area. O. Reg. 79/10, s. 136 (4).
2. The name of the resident for whom the drug was prescribed, where applicable. O. Reg. 79/10, s. 136 (4).
3. The prescription number of the drug, where applicable. O. Reg. 79/10, s. 136 (4).
4. The drug's name, strength and quantity. O. Reg. 79/10, s. 136 (4).
5. The reason for destruction. O. Reg. 79/10, s. 136 (4).
6. The date when the drug was destroyed. O. Reg. 79/10, s. 136 (4).
7. The names of the members of the team who destroyed the drug. O. Reg. 79/10, s. 136 (4).
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the drug destruction and disposal policy included documentation of the following in the drug record:

The date of removal of the drug from the drug storage area.
The name of the resident for whom the drug was prescribed, where applicable.
The prescription number of the drug, where applicable.
The date when the drug was destroyed.
The manner of destruction of the drug.

Review of the home's Medication Management Policies 2_1 to 2_8 did not reveal a process for the documentation for the drug destruction record which included the relevant requirements. In addition, a review of the drug destruction record from April 19 to June 4, 2014 revealed the following missing documentation:
The date of removal of the drug from the drug storage area (x10)
The name of the resident for whom the drug was prescribed, where applicable (x1)
The prescription number of the drug, where applicable (x10)
The date when the drug was destroyed (x10)
The manner of destruction of the drug (x10)

This was confirmed by the CEO on June 16, 2014. [s. 136. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

An observation of medication administration revealed the following:
- limited handwashing (3/10 times hands were washed) between residents when administering medications
- no handwashing, then handling medications with fingers and putting in medication cup
- no handwashing, then breaking open capsule (medication) and putting in medication cup
- no alcohol swab use for the top of the insulin bottle before inserting needle to draw up insulin

The CEO verified the expectation of the home is to handwash between residents when providing medication and that alcohol swabs should be used for the top of insulin bottles before the insertion of a needle. [s. 229. (4)]

Issued on this 25th day of June, 2014

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