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 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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 22, 2017	2016_268604_0022	032414-16	Resident Quality Inspection

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

ELGINWOOD
182 YORKLAND STREET RICHMOND HILL ON L4S 2M9

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

SHIHANA RUMZI (604), ROMELA VILLASPIR (653)

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): This inspection was conducted on the following date(s): November 15, 16, 17, 21, 22, 23, 24, 25, 28, 29, and 30, 2016.

During the course of the inspection, the following intake logs where carried out concurrently with the RQI:
Provision of Care
Log #003996-14

Food Production and Snack Service
Log #004050-15
Log #019335-16

Alleged Abuse/Neglect
Log #010074-14
Log #032891-16

Environmental Services
Log #033016-16

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Directors of Care (DOC), Assistant Director of Care (ADOC), Programs Manager (PM), Food Services Manager (FSM), Registered Dietitian (RD), Dietary Aide (DA), Office Manager (OM), Previous Executive Director (PED), Previous Director of Care (PDOC), Residents Services Coordinator (RSC), Wound Care Champion (WCC), Environmental Services Manager (ESM), Maintenance Staff (MS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Private Sitter (PS), family members, Resident Council President and residents.

During the course of the inspection, the inspectors conducted a tour of the home including resident home areas, medication administration observation, snack observation, observed resident and staff interactions, reviewed clinical health records, relevant home policies and procedures, education records and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation

During the course of this inspection, Non-Compliances were issued.

8 WN(s)
5 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	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. 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 :

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Resident #005 was triggered in stage one for an identified care area through census record review.

Record review of the home's policy titled "Weight and Height Monitoring Index: CARE7-O10.03" reviewed on July 31, 2016, indicated under procedure that "Residents are weighed and the weight documented by the 7th day of each month. If a weight loss or gain is 2.0 kg or greater from the preceding month, the weight will immediately be confirmed".

Record review of resident #005's identified report indicated that the resident had lost 7 kilograms with in an identified period of time.

Record review of resident #005's identified report did not indicate that the resident was re-weighed in an identified month.

Interview conducted with Registered Nurse (RN) #105 stated that resident #005 was not re-weighed when he/she experienced a 7 kg weight loss with in an identified period of time.

Interview with the RN and the Registered Dietitian (RD) indicated the home's policy was that a re-weigh was to be carried out with a weight loss or gain of 2.0 kg and confirmed a re-weigh was not carried out when resident #005 had lost 7kg.

2. During stage one of the RQI resident #004 was triggered related to eating decline through MDS Admission to 90 day assessment.

Record review of the home's policy titled "Weight and Height Monitoring Index: CARE7-O10.03" reviewed on July 31, 2016, indicated under procedure that "Residents are weighed and the weight documented by the 7th day of each month. If a weight loss or gain is 2.0 kg or greater from the preceding month, the weight will immediately be confirmed".

Record review of resident #004's identified report indicated that his/her weight taken

between month A and B showed a 3.3 kg weight loss.

Record review of resident #004's weight summary report did not indicate that his/her weight on month B was confirmed. There was no information obtained to indicate that a re-weigh had been completed.

Interview with the RD, stated that resident #004 was not re-weighed when he/she experienced a 3.3 kg weight loss between month A and month B.

Interview with the DOC stated that the home's expectation was for residents to be re-weighed immediately when there was a 2 kg or more, gain or loss from the preceding month and the staff did not carry out a re-weigh for resident #004.

3. Resident #017 was triggered in stage two for worsening alteration in skin integrity through MDS Previous to Most Recent assessment.

Record review of resident #017's TAR revealed that his/her altered skin integrity had not been documented through photograph for an identified month in 2016.

An interview with the home's WCC acknowledged resident #017's altered skin integrity was not documented through photograph for an identified month in 2016.

Record review of the home's policy titled "Skin and Wound Program", index: LTC-E-90, revised date August 2015, under Documentation/ Monitoring, item #11 indicated that: Wounds will be photographed initially and at least monthly as per best practice.

An interview with the DOC stated that the home's expectation was for altered skin integrity to be photographed on a monthly basis to assess its progression/healing and a photograph of resident #017's alteration in skin integrity was not carried out as per home's policy. Resident #017 was triggered in stage two for worsening alternation in skin integrity.

4. Resident #017 was triggered in stage two for worsening alteration in skin integrity through MDS [P-MR] assessment.

Record review of resident #017's initial alteration in skin integrity which was carried out on an identified date, indicated that the resident was assessed with an identified stage of alteration in skin integrity on an identified location of his/her body, due to trauma from an

identified personal resident equipment.

A review of the eTAR records for an identified period for resident #017's revealed an identified treatment for the identified area of alteration of skin integrity.

Record review of the Revera/3M Clinical Resource Guide for Skin & Wound Care binder, did not identify an identified dressing as one of the dressings to be applied on an identified stage of alteration in skin integrity.

An interview with RPN #127 confirmed that resident #017 received an identified dressing for the identified treatment of alteration of skin integrity for an identified period of time. RPN #127 further indicated that resident #017 did not receive the appropriate treatment for an identified period of time, according to the Revera/3M Clinical Resource Guide for Skin & Wound Care.

Record review of the home's policy titled "Skin and Wound Program", index: LTC-E-90, revised date August 2015, indicated under interventions, item #2:The Interdisciplinary Skin & Wound Care Team will utilize Treatment Algorithms for altered skin integrity to guide clinical decision-making. These are located in the Revera/3M Clinical Resource Guide for Skin & Wound Care which is available in all Homes.

Interview with the WCC confirmed that the home's expectation was for registered staff to carry out wound treatment interventions according to the Revera/3M Clinical Resource Guide for Skin & Wound Care binder and resident #017 did not receive the care as directed.

5. On an identified date and home area, Inspector #653 conducted a mandatory narcotic storage area observation with RPN #111 and reviewed the narcotic count sheet.

Inspector #653 observed the following discrepancies:

-Resident #010's identified As needed (PRN) narcotic blister pack consisted of 12 tablets whereas the individual count sheet indicated resident #010 had 13 tablets remaining.

-Resident #011's identified PRN narcotic blister pack consisted of 19 tablets, whereas the individual count sheet indicated resident #011 had 20 tablets remaining.

-Resident #012's identified PRN narcotic blister pack consisted of 11.5 tablets, whereas

the individual count sheet indicated resident #012 had 12 tablets remaining.

Interview with RPN #111 stated that when the above mentioned PRN narcotics were administered to the residents, the dose of the narcotics given were not documented on the individual count sheets.

The home follows Classic Care Pharmacy's policy titled "Administering and Documenting Controlled Substances", policy number: 4.3, revised date November 2015, under procedure item number one and two directed staff to:

1. Locate the Resident's MAR sheet, individual count sheet and controlled substance medication. Each controlled substance medication is individually inspected and verified for correctness against the Resident's MAR sheet, verifying competence, safety and authority.

2. The dose of the controlled substance medication is documented, recording the:
a. Date and time,
b. Administered quantity
c. Remaining quantity
d. Signature of administering person".

An interview with the DOC indicated that the home's expectation was for registered staff to document on the individual narcotic count sheets after administering narcotics to the residents and verified the nurse did not follow the home's policy.

6. On an identified date and home area, Inspector #653 and RPN #111 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication. Inspector #653 and RPN #111 observed resident #012's identified narcotic blister pack consisted 30 tablets.

Record review of resident #012's individual narcotic and controlled drug count sheet did not show an amount received from pharmacy signed off by a nurse verifying the count.

Record review of the Classic Care Pharmacy shipping report indicated resident #012's blister pack for an identified narcotic medication consisted of 30 tablets with an identified received date.

The home follows Classic Care Pharmacy's policy titled "Administering and Documenting

Controlled Substances”, policy number: 4.3, revised date November 2015, under procedure item number four, indicated: it is the responsibility of the nurse to sign and document the starting count on the individual count sheet when the controlled substance is received.

An interview with RPN #111 stated that the nurse who had received resident #012’s identified narcotic blister pack should have signed and documented the starting count on the individual narcotic and controlled drug count sheet.

An interview with the DOC indicated that the home’s expectation was for the receiving nurse to sign and document the starting count of the individual count sheets and confirmed resident #012’s narcotic and controlled drug count sheet was not signed off by the receiving nurse for the identified medication.

7. On an identified date and home area, Inspector #653 and RPN #111 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication. Inspector #653 and RPN #111 observed that resident #013’s identified narcotic did not have an individual count sheet.

Record review of the home’s policy titled “Management of Narcotic and Controlled Drugs/ Benzodiazepines-Ontario”, index: LTC F-80-ON, revised date November 2013, under standard operating procedure item two one and three, indicated:

2. The Nurse will document the receipt of the drugs on a Narcotic and Controlled Drug Count Form (Drug Record Book).

3. Narcotic and controlled drug(s) are then documented on the Unit's Narcotic and Controlled Drug Count sheet link to 2 shifts/24 hours tool [LTC-F-80-05-ON] or 3 shifts/24 hours tool [LTC-80-10-ON] and on the Individual Resident's Narcotic and Controlled Drug Count sheet [LTC-F-80-15-ON], located in a separated binder, and/or on the Medication Administration Record (MAR) binder, which will be stored in the medication room when not in use”.

Interviews with RPN #111 and the DOC confirmed that there was no individual count sheet for resident #013’s identified narcotic.

An interview with the DOC indicated that the home’s expectation was for each narcotic drug to have its own individual count sheet, and for registered staff to document on the

individual count sheet upon receipt of the narcotic in the home.

8. Resident #005 was triggered in stage two for the use of personal resident equipment which was observed to be used.

Multiple observations were conducted for resident #005’s personal resident equipment, with each observation the inspector observed the personal resident equipment to be utilized when resident was in an identified location of the home.

Documentation review indicated the following:
-Two reviews of the Resident Assessment Instrument (RAI) MDS indicated resident #005 utilized the identified resident personal equipment on a daily basis.

- On an identified date a physician order stated the identified resident personal equipment was the family’s request.

-On an identified date the written plan of care, indicated resident #005 utilized the identified resident personal equipment, as per family’s request.

An interview with RN #124 indicated if a resident is identified utilizing the resident personal equipment and is unable to move and family request the resident personal equipment he/she believes an identified assessments is to be carried out quarterly or with any changes. The RN confirmed resident #005 utilized an identified resident personal equipment, is unable to move his/her extremities and is unable to use the identified equipment. Teh RN added that it was the family's request to have the identified resident personal equipment and the identified resident personal equipment was put in place and a doctor's order was obtained as the identified resident personal equipment may put the resident at risk. The RN looked at the Point Click Care (PCC) assessments tab no evidence of an identified assessments was not carried out quarterly for resident #005.

Home’s policy “Resident Safety”, “Least Restraints”, index: LTC-K-10, with a revised date of March 2013, indicates in the intervention/documentation section number seven: ongoing use of restraint(s) will be reviewed at least quarterly by the Interdisciplinary Team and discussed at the annual care conference with the focus being restraint reduction.

Interviews conducted with the Associate Director of Care (ADOC) and DOC indicated

resident #005 utilized the identified resident personal equipment as per family's request and stated resident was unable to mobilize in him/herself. The ADOC and DOC indicated if the resident personal equipment is identified as a risk to the resident a quarterly identified assessment is to be carried out and stated that they were unable to find an identified assessment for resident #005 and did not follow home's policy.

9. Resident #005 was triggered in stage two for the use of personal resident equipment which was observed to be used.

Multiple observations were conducted for resident #005's personal resident equipment, with each observation the inspector observed the personal resident equipment to be utilized when resident was in an identified location of the home.

Documentation review indicated the following:
-Two reviews of the Resident Assessment Instrument (RAI) MDS indicated resident #005 utilized the identified resident personal equipment on a daily basis.

- On an identified date a physician order stated the identified resident personal equipment was the family's request.

-On an identified date the written plan of care, indicated resident #005 utilized the identified resident personal equipment, as per family's request.

An interview with resident #005's the Substitute Decision Maker (SDM) indicated he/she had requested to have the identified resident personal equipment used for the resident since admission for resident safety. The SDM indicated he/she did not recall the home speaking to him/her related to the risks associated with the use of the identified resident personal equipment.

Home's policy “Resident Safety”, “Least Restraints”, index: LTC-K-10, with a revised date of March 2013, indicates in the intervention/documentation section number one: the resident/SDM/family will be fully informed about the type of restraint, procedures, and potential risks and burdens associated with the restraint being considered.

An interview conducted with the ADOC indicated the home would speak to the family related to the risk associated with the use of the identified resident personal equipment and document the conversation on a progress note. The ADOC indicated he/she was unable to find evidence in the progress note of the home speaking with the family related

to the risk associated with using of the identified resident personal equipment.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #005 was triggered in stage two for the use of personal resident equipment which was observed to be used.

Multiple observations were conducted for resident #005's personal resident equipment, with each observation the inspector observed the personal resident equipment to be

utilized when resident was in an identified location of the home.

Documentation review indicated the following:
-Two reviews of the Resident Assessment Instrument (RAI) MDS indicated resident #005 utilized the identified resident personal equipment on a daily basis.

- On an identified date a physician order stated the identified resident personal equipment was the family's request.

-An identified assessment was carried out by the home on identified resident personal equipment. The entrapment indicated serial number for the identified resident personal equipment and if the equipment passed the areas of risk. No evidence was found to demonstrate resident #005's identified resident personal equipment was assessed and the equipment was evaluated.

- An identified assessment was carried out by the home on identified resident personal equipment indicated: resident is unable to make decisions independently, does not require the identified resident personal equipment for mobility, resident is unable to get in and out of bed on his/her own, does not attempt to get in and out of bed on his/her own, resident is immobile, hi-low bed provided, and that POA requested to have the identified resident personal equipment

-On an identified date the written plan of care, indicated resident #005 had the identified resident personal equipment as per family's request.

Interviews conducted with the ADOC and DOC indicated the home conducts annual identified resident personal equipment assessments utilizing Joren's the vendor for each identified resident personal equipment in the home. The ADOC and DOC confirmed that resident #005 was utilizing an identified resident personal equipment as per family's request and resident is immobile. The ADOC and DOC stated resident#005 was not assessed and his/her identified resident personal equipment was not evaluated to minimize the risk to resident.

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 where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, 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 :

The licensee has failed to ensure that the 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.

During stage two resident #017 was triggered for alteration in skin integrity through MDS assessment.

Record review of an identified time period in 2016, of resident #017's ETAR records, directed staff to complete a skin/wound assessment including the wounds measurements on an identified day, in the TAR binder.

Record review of resident #017's ongoing alteration in skin integrity, TOR sheets in the TAR binder, revealed that the weekly wound assessments for an identified period of time was not completed.

Record review of resident #017's progress notes for an identified period of time in 2016, did not indicate a weekly wound assessment using a clinically appropriate assessment instrument for alteration in skin integrity had been carried out.

An interview with RPN #127, confirmed that the weekly wound assessments on resident #017's alteration in skin integrity was not completed on the identified dates.

Interviews with the homes' WCC and DOC, stated that the home's expectation was for registered staff to complete weekly wound assessments on alteration in skin integrity and indicated alteration in skin integrity assessments were not completed on the dates indicated for resident #017.

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 resident exhibiting a pressure ulcer was 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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the planned menu items were offered and available at snacks.

On an identified date and time, an anonymous complaint was brought to the attention of the inspectors related to snack delivery on an identified home area. The inspector was informed of the following:
-At an identified snack service the PSWs touch the snacks with bare hands and no hand hygiene is carried out between residents.

A snack observation was carried out by the Inspector on an identified date and home area. The snack menu indicated peanut butter and jelly (PB&J) sandwiches for the evening snack. The inspector observed the snack cart being left in the servery by the Dietary Aid (DA) #134 at 1845 hrs, the snack cart consisted of one jug of water nectar thick, nectar thick apple juice, regular apple juice, regular cranberry juice, and a carrot loaf.

The Inspector observed the full snack service on an identified home area at an identified time which was carried out by two PSW staff. The Inspector observed the two PSW staff offer the snack provided to the residents and used tongs to serve the snack. Interview with PSW #122 informed inspector snack menu posted on the snack cart indicates PB&J for an identified date and shift and stated was given a carrot loaf on the snack cart instead. The PSW further indicated he/she was not informed of the change in snack as they did not see a DA in the servery.

An interview with the homes' Food Services Manager (FSM) confirmed on an identified date, the snack was PB&J as indicated on the snack menu. The FSM indicated that he/she was not informed or aware if there was a change in the snack menu. The FSM returned to the Inspector and indicated the cook provided carrot loafs was provided on an identified date to the identified home are instead as the cook indicated they did not have enough peanut butter to make sandwiches for evening snack service. The FSM confirmed the snack on menu was not offered.

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 planned menu items was offered and available at snack, to be implemented voluntarily.

WN #5: 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 :

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

Medication administration observation was carried out on an identified date and home area. Inspector #653 observed RPN #111 administer medications to residents' #006, #007, #008, and #009 consecutively and did not perform hand hygiene in-between the four residents.

An interview with RPN #111 indicated it was the home's expectation to carry out hand hygiene between administering medications to residents and stated that he/she did not sanitize his/her hands in between administering medication to the above indicated residents.

An interview with the DOC indicated it was the home's expectation for staff to complete hand hygiene in-between residents when administering medications.

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 staff participated in the implementation of the infection prevention and control program, 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:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On an identified date and time, Inspector #653 was walking towards resident #017’s bed room to carryout observations, the inspector observed resident #017’s room door was half opened. From the hallway the Inspector was able to see resident #017’s legs exposed. When Inspector walked closer to the door, he/she noted that resident #017 was unclothed in bed while PSW #136 was providing care to the resident.

An interview with PSW #136 confirmed resident #017’s room door was left half-open and not fully closed when he/she was providing care to resident #017 and did not provide privacy during care.

An interview with the DOC stated that the home's expectation was to close resident’s room doors when providing care.

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:

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).

Findings/Faits saillants :

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

1.The following observations were made during the mandatory medication observation as a part of the Resident Quality Inspection (RQI) conducted on an identified home area by inspector #653:
-On an identified date and time, the inspector observed Registered Practical Nurse (RPN) #111 crush resident #007's medications and administered the medication to the resident.
-On an identified date and time, the inspector observed RPN #117 crush resident #007's medication and administered the medication to the resident.

Record review of resident #007's written plan of care completed on an identified date, three month medication review, and resident #007's identified Electronic Medication Administration Record (E-MAR) did not indicate direction to crush resident's medications prior to administration.

Interviews with RPNs #111 and #117 confirmed that there was no direction in resident #007's written plan of care directing the nurses that medications were to be crushed.

An interview with the Director of Care (DOC) stated that resident #007's written plan of

care did not provide clear direction to staff, in regards to crushing the resident's medications. The DOC further indicated that the direction to crush resident #007's medications should have been included in the resident's written plan of care.

2. During stage two of the RQI, resident #017 was triggered for alteration in skin integrity in stage two through the MDS assessment.

Record review of resident #017's initial wound assessment carried out on an identified date, indicated the resident was assessed with alteration in skin integrity on an identified area of his/her body, due to trauma from an identified personal health equipment.

Record review of the progress notes indicated resident #017 was admitted to the home with the identified personal health equipment in place.

Record review of resident #017's written plan of care completed on three identified months in 2016, did not provide direction as to when the identified personal health equipment was to be provided care.

An interview with RPN #127 confirmed that resident #017's written plan of care did not identify the direction in regards to caring for the identified personal health equipment.

The DOC indicated that the home's expectation was if a resident identified with an identified personal health equipment, his/her written plan of care should include direction as to when care is to be provided according to best practice. The DOC confirmed that resident #017's written plan of care did not provide clear directions as to when the care was to be provided for the identified personal health equipment.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On an identified date and home area, during an identified shift snack observation the inspector observed the following:

A family member approached RPN #123 who was in an identified area of the home and requested an identified medication for their loved one, the RPN was observed by the inspector to give the medication to the family in a white paper medication cup. The family member was observed going up the hall in to an identified room. The family member went into the room with the medication. The Inspector was unable to see into the room as the door was partly closed. As inspector was outside the room door the RPN came running down the hall and went into the room and come right back out. The inspector knocked the room door and spoke with resident #021's family.

An interview with resident #021's family member indicated he/she was the residents SDM and that he/she comes to the home each day. The POA confirmed the above observation and indicated he/she administered the identified medication to the resident and the nurse came in to the room right after he/she administered the medication.

An interview with RPN #123 indicated it is only the home's nursing staff that can administer medication to a resident and confirmed the above observation. The RPN indicated the family administered the medication to resident #021 but went in to the room.

An interview with the DOC stated only registered staff are to administer medications. The DOC was informed of the above observation and the DOC indicated the RPN should not have given the family the identified medication to administer and did not follow process.

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.