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

Division de la responsabilisation et de la performance du système de santé
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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
Aug 11, 2015	2015_256517_0021	014825-15	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

HERON TERRACE LONG TERM CARE COMMUNITY
11550 McNorton Street WINDSOR ON N8P 1T9

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

PATRICIA VENTURA (517), ALISON FALKINGHAM (518), SANDRA FYSH (190)

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): July 6, 7, 8, 9, 13 & 14, 2015

The following Critical Incidents were completed concurrently during this Resident Quality Inspection:
Log #007166-15/2898-000008-15 related to alleged abuse/neglect
Log #014498-15/2898-000011-15/2898-000012-15 related to improper treatment of a resident that results in harm or risk of harm to the resident

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Acting Manager of Resident Care, the Manager of Environmental Services, the Manager of Life Enrichment, the Manager of Food Services, the RN/RAI Coordinator, three Registered Nurses, three Registered Practical Nurses, six Personal Support Workers, approximately 40 residents and three family members.

During this inspection, the inspectors observed staff to resident interactions, resident to resident interactions, dining services and a medication pass. The inspectors toured resident home areas and reviewed policies and procedures as well as meeting minutes applicable to this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **4 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Health record review revealed Registered Staff assessed a resident to have assessment findings that were uncommon for this resident.

Two Registered Staff members confirmed the Physician was not notified of the above uncommon assessment findings by Registered Staff and did not have the opportunity to collaborate with the staff in the assessment of the resident so that their assessments were integrated and were consistent with and complement each other and this was the expectation. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

Health record review revealed a resident had a change in condition affecting the resident's daily activities.

Review of the plan of care for the resident revealed the plan of care was not updated since the resident had a change in condition.

Two Registered staff members confirmed that the plan of care was not updated with the most current information. [s. 6. (10) (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 that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary; to ensure that staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was maintained in a good state of repair.

During stage one and stage two observations of the home the following issues were identified on two units:

- Wall damage noted on the wall to left when entering lounge
- Vents on bottom of utility room doors had debris noted in them
- The floor in one resident room had three holes in the flooring
- When entering the community room, the transition between the carpet and flooring had significant black debris along both edges
- The legs of resident chairs in multiple resident rooms were quite scuffed and marked
- Wall damage was noted in two resident rooms
- The floors in three resident rooms were noted to have black areas and required cleaning

Interview with the Environmental Manager revealed that the floors in three resident rooms required deep cleaning to be stripped and re-waxed. The Environmental Manager also noted that the resident in one of the rooms refused to have the bedroom floor re-done.

The Environmental Manager accompanied inspector on the walk-through and confirmed the maintenance required in these areas.

Observations revealed one servery had a build-up of dirt and debris around the edges and particularly under the refrigerator and around the dish machine.

The Manager of Food Services confirmed that this servery did require deep cleaning of the areas noted. [s. 15. (2) (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 to ensure that the home is maintained in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that, (a) could be easily seen, accessed and used by residents, staff and visitors at all times.

Interview with one resident revealed the resident was waiting for someone to come in the resident's room because the call bell was not within reach. The resident expressed not being able find the call bell and wanting to request a treatment. While in the resident's room the inspector observed the call bell not within reach of the resident.

Interview with a Registered Practical Nurse revealed the resident should have his call bell accessible and this was not done.

The Acting Administrator confirmed the expectation that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a PASD that is used to assist a resident with a routine activity of living was included in the resident's plan of care.

A resident was observed seated in a tilted wheelchair. Interview with staff revealed the tilt wheelchair was used as a Personal Assistive Service Device (PASD)for this resident.

The home's policy titled: "PASD's (Personal Assistive Service Devices) Policy #RCM 10-09 revised June 2, 2015 indicated: "The Resident's care plan must indicate how, when and why the device is to be used as a support to promote independence and quality of life. The plan of care must indicate when to remove the device as soon as it is no longer required for assisting with activities of daily living".

Health record review revealed the use of the tilt wheelchair as a PASD was not in the written plan of care for this resident and consent had not been obtained from the Power of Attorney for the use of this PASD.

Two Registered Nurses confirmed the tilt function on the wheelchair was being used as a PASD for this resident. The two Registered Nurses confirmed the expectation that this PASD should be included in the written plan of care for this resident and this was not done. [s. 33. (3)]

Issued on this 12th day of August, 2015

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

Original report signed by the inspector.