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
Feb 5, 2016	2015_298557_0015	027065-15	Resident Quality Inspection

Licensee/Titulaire de permis

HILLCREST VILLAGE INC.
255 RUSSELL STREET MIDLAND ON L4R 5L6

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

HILLCREST VILLAGE CARE CENTRE
255 RUSSELL STREET MIDLAND ON L4R 5L6

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

VALERIE PIMENTEL (557), ANN HENDERSON (559), MATTHEW CHIU (565)

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): October 2, 5, 6, 7, 8, 9, 13, 14, 15 and 16, 2015.

The following Critical Incident Intakes were inspected concurrently with the Resident Quality Inspection: T-1439-14, T-2524-15 and T-2917-15.
During this inspection, the inspector conducted an inquiry to Complaint log T-1461-14.

During the course of the inspection, the inspector(s) spoke with the Assistant Administrator (AA), Director of Resident Care (DORC), Assistant Director of Resident Care (ADORC), Resident Care Facilitator (RCF), interim Program Co-ordinator, Nutrition Manager (NM), Maintenance Supervisor, Housekeeping and Laundry Supervisor, Nursing Administration Support Co-ordinator, Registered Nurses (RN), Registered Practical Nurse (RPN) Personal Support Worker (PSW), Health Care Aide (HCA), Cook, Housekeeping Aide, Residents' Council President, Residents and Family members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents' Council, menus, recipes, staffing schedules, observation of infection prevention practices and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **5 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 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the home's policy titled: Fall Risk Assessment and Management Policy and Procedure, revised date: January 16, 2014, indicated when a resident falls and there is evidence or suspicion of injury, the staff member should contact the physician immediately with history and have vital signs readily available and follow the physician's order for continued monitoring and assessment.

A review of the progress notes, post fall assessment and physiotherapy assessment revealed resident #012 fell in May 2015, in his/her room and sustained an injury to his/her upper body, resulting in the resident experiencing upper body pain and stiffness. Further review of the progress notes indicated the resident was given pain medication and staff did not contact the physician until several days after the fall occured. The physician then ordered the resident to be transferred to hospital for an assessment. The resident was diagnosed with a significant injury.

Interviews with the registered staff and the DORC confirmed the home failed to comply with the policy to contact the physician immediately after the resident fell with an injury. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the home's policies titled: Lost Personal Laundry, revised date: November 2012, and "Missing Items Policy and Procedure" approval date: November 1, 2012, indicated the following:
- When a resident or family member reports any missing clothing and the item is not found, staff should complete a tracking form and send a copy to the laundry department and leave a copy at the nursing station.
- If the item missing is not an article of clothing or linen, staff should follow up with the resident or family member and enter the information in Missing Item Incident Report in PointClickCare (PCC).

An interview with the family member of resident #011 revealed the resident had lost several articles of clothing and the family had reported it to the home in November 2014.

Record review revealed a tracking form and PCC Missing Item Incident Report were not completed for both missing clothing and personal belongings.

An interview with the DORC confirmed the family had reported the missing items to the home and the home failed to follow the policies to record the missing items on the tracking form and the PCC Missing Item Incident Report. [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 that the following policies:
- Fall Risk Assessment and Management Policy and Procedure, and
- Lost Personal Laundry policy, are complied with, to be implemented voluntarily.

WN #2: 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. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of resident #011's plan of care and admission risk for falls assessment dated in October 2014, revealed the resident was at risk for falls.

A review of the progress notes revealed the resident fell on two seperate occasions in November 2014, and a Post Fall Assessment had not been completed.

Interviews with a registered staff member and DORC confirmed the home uses a Post Fall Assessment instrument that is specifically designed for falls to assess a resident when a fall occurs. The DORC confirmed no post-fall assessment had been conducted for the resident using the home's Post Fall Assessment instrument. [s. 49. (2)]

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 that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed 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.

A review of the progress notes revealed resident #011 fell in November 2014, in his/her room. Record review of the resident's plan of care and admission risk for falls assessment dated in October 2014, revealed the resident was at risk for falls and the following falls prevention interventions had been implemented:
- Yellow star placed outside the resident's room, and
- Follow fall protocol

Further review of the resident's plan of care indicated no clear direction for the fall protocol set out for the resident.

Interviews with registered nursing staff and RCF #120 confirmed that they did not know what was specified in the fall protocol and that the plan of care did not set out a clear direction to staff who provide direct care to the resident. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure all food and fluids prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

Record review of the plan of care and dietary assessments identified resident #005 as being at a high nutritional risk related to swallowing difficulties and is to receive a therapeutic regular diet.

An interview with the resident revealed the therapeutic textures are not consistent; this had been reported to the NM in July 2015, and continued to occur. The resident revealed the texture of the vegetable on an identified day in October 2015, was not smooth.

Review of the Residents' Council minutes for July 2015, revealed the resident had complained the therapeutic textures were not smooth and at the food committee in October 2015, the resident further complained about the therapeutic textures not being smooth.

An interview with a cook revealed after preparation all therapeutic food is placed in the steamer oven and requires to be double wrapped; if steam gets into the therapeutic textured vegetables the consistency may be altered and the vegetables would not be smooth. The cook confirmed there is a recipe for all therapeutic food; however a recipe for the therapeutic succotash could not be located in the recipe book.

An interview with the NM revealed there should be specific therapeutic recipes for staff to follow and subsequently provided the staff with the specific recipe. The NM confirmed the home had failed to serve therapeutic food which preserved taste and appearance for the resident. [s. 72. (3) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 87 (2).
(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; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odors.

During an interview with resident #008 and observation of the resident's room on October 5, 13 and 14, 2015, with resident #008, the inspector identified a lingering odor in the identified room.

Record review of the written care plan and staff interviews revealed the resident is incontinent of urine, requires continence products and assistance with personal hygiene.

An interview with an identified housekeeper revealed there are lingering odors in two resident rooms. The housekeeper revealed he/she uses an enzyme cleaner, deep cleans the bedroom and bathroom floors and previously in an identified room the family removed identified articles due to lingering odors.

The housekeeper further revealed another room had been identified with lingering odors and the procedures in practice does not address the lingering odors from residents #027 and #028 whom reside in this room.

On October 2015, the housekeeper confirmed the strong urine odor in an identified room came from a resident’s personal items.

An interview with the housekeeping and laundry supervisor revealed lingering odors in the identified rooms as an ongoing problem and the procedures developed and implemented for addressing incidents of lingering offensive odors had not been effective. [s. 87. (2)]

Issued on this 23rd day of February, 2016

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

Original report signed by the inspector.