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
Jul 23, 2015	2015_226192_0041	014807-15	Resident Quality Inspection

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

LANARK HEIGHTS LONG TERM CARE CENTRE
46 LANARK CRESCENT KITCHENER ON N2N 2Z8

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

DEBORA SAVILLE (192), NATALIE MORONEY (610), SHERRI GROULX (519)

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 7, 8, 9, 10, 13, 14 and 15, 2015

This Resident Quality Inspection was conducted concurrently with:
complaint inspection 008404-15 related to resident assessment, management of responsive behaviours and pain management and
complaint inspection 011611-15 related to personal care, skin and wound and laundry.

Critical Incident Inspection 017328-15 related to an allegation of staff to resident abuse was included in this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care, Assistant Managers of Resident Care, Food Services Manager, Social Worker, Resident Assessment Instrument (RAI) Coordinator, Staffing Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Students, Dietary Aids, Environmental Maintenance Manager, Recreation Aid, Housekeeper, family members and residents.

Inspectors also toured the home, observed meal service, medication administration, medication storage areas, recreation activities and care provided to residents, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home. Inspectors reviewed relevant clinical records, policies and procedures.

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
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
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **7 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. (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 the written plan of care for the resident set out clear directions to staff and others who provide direct care to the resident.

During observation on a specified home area, specified rooms were noted to have signage on the door.

Record review of resident #020 revealed a physician order directing staff to use specified precautions when providing care to the resident.

The Manager of Resident Care (MRC) confirmed that active disease diagnosis would be care planned and that all staff have access to the plan of care. The MRC confirmed that the interventions required had not been included in the written plan of care.

The licensee failed to ensure that the plan of care provided clear direction to staff and others who provide direct care to resident #020. [s. 6. (1) (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 ensuring that the written plan of care for the resident sets out clear directions to staff and others who provide direct care to the resident, 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 :

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

Inspector #519 observed Resident #005's bed system to have bilateral full rails in the up position and a specified mattress in place, staff confirmed that the resident was not able to get out of bed on their own.

Interview with the Environmental Manager confirmed that resident #005's bed entrapment audit had been completed in 2014 and that the bed had failed at least one zone of entrapment, using the bed audit system tool.

Review of resident #005's health care record revealed that there was no completed assessment of the resident's risk for entrapment in a bed that had failed at least one zone of entrapment.

The Manager of Resident Care (MRC) confirmed that there was no assessment of entrapment risk completed for Resident #005.

The MRC confirmed that it was the homes expectation that all residents at risk for bed entrapment would have a quarterly assessment to minimize the risk of bed entrapment and that resident's bed systems that fail the bed entrapment audits should be reviewed to minimize the risk to the residents.

The licensee failed to ensure that resident #005 had been assessed in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

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 ensuring that the resident had been assessed and his or her bed system 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. 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 has 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 were documented.

Resident #013 was observed to have an injury.

Resident interview confirmed that the resident was aware of the cause of the injury, and that staff were aware of the injury and had questioned the resident in regard to it.

Record review, confirmed by the Manager of Resident Care (MRC), failed to identify documentation of the injury to resident #013.

The MRC confirmed that any staff member identifying an area of altered skin integrity should record the change in condition in Point Click Care and report the concern to the charge nurse. The charge nurse would be responsible to assess the change and would record the altered skin integrity in the progress notes.

The MRC confirmed that resident #013 had a task related to monitoring skin condition, on Point of Care, and that staff had not recorded a change in skin condition.

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

2. The plan of care for resident #007 indicated under falls that staff were to check the resident every thirty minutes to ensure safety and to chart on Point of Care.

Interview with the Manager of Resident Care identified there was no policy related to the use of Point Click Care and indicated that the expectation was that staff would document interventions as close to the time of the provision of care, as possible and would not bulk chart.

Review of Point of Care documentation for resident #007 identified that on a specified dates in 2015, documentation related to checking the resident every thirty minutes was not completed at specified times.

Documentation of resident checks for a specified date in 2015 at specified times were completed within a three minute window. Interview with the Manager of Resident Care confirmed that "bulk" charting completed for thirty minute periods specified did not confirm that the resident was checked each 30 minute period and the policy titled Resident Chart - Documentation in Point Click Care Progress Notes indicated that staff are never to document before providing care and that if it was not charted it was not done.

Resident #007 sustained a fall on a specified date in 2015, that resulted in transfer to hospital.

The licensee failed to ensure that actions taken with respect to checking resident #007 every thirty minutes were documented at the specified times. [s. 30. (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 ensuring 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, to be implemented voluntarily.

WN #4: 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 has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure, ulcers, skin tears or wounds was reassessed at last weekly by a member of the registered nursing staff, if clinically indicated.

Resident #007 was documented to have sustained altered skin integrity on a specified date in 2015.

Review of the Treatment Administration Record (TAR) failed to identify documentation on the TAR of the altered skin integrity and treatment required, including weekly wound assessment.

No weekly assessment of the altered skin integrity was documented and there was no indication in the medical record of when the area of altered skin integrity had healed.

Interview with the Manager of Resident Care confirmed that the area of altered skin integrity was not included on the TAR and weekly wound assessments were not completed related to this area of altered skin integrity. [s. 50. (2) (b) (iv)]

2. Resident #001 sustained an area of altered skin integrity on a specified date in 2015, after a fall. An assessment of the injury was completed ten days later by a registered staff member.

Observation of resident #001 confirmed the presence of the specified injury twelve days after the area of altered skin integrity was reported.

Interview with a registered staff member identified that skin assessments are done when a resident has altered skin integrity and are usually done in the progress notes under focus notes.

Interview with the Manager of Resident Care confirmed that it was the home's expectation that a resident with altered skin integrity would have a skin assessment done weekly.

The licensee failed to ensure that resident's #001 and #007 received weekly wound assessments in relation to altered skin integrity. [s. 50. (2) (b) (iv)]

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 ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure, ulcers, skin tears or wounds is reassessed at last weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #011 was identified to be occasionally incontinent of urine and continent of bowel at the time of admission in 2012.

Minimum Data Set (MDS) assessment completed on a specified date in 2013, identified resident #011 to be frequently incontinent of bladder. MDS assessment completed on a specified date in 2014, identified resident #011 to be occasionally incontinent of bowel and an assessment completed on a specified date in 2015, indicated the resident was frequently incontinent of bowel.

Interview with the Manager of Resident Care confirmed that the MDS assessments indicated a change in the resident's continence and continence assessments should have been completed.

The home's policy titled Bladder and Bowel Continence indicated that a resident's continence would be reassessed if H4 Change in Urinary and/or Bowel Continence is coded as deteriorated during quarterly MDS or change in status.

Record review and interview with the MRC confirmed that no continence assessment was conducted for resident #011 at the time of admission, with a change in urinary continence on the specified date in 2013, or with a change in bowel continence on specified dates in 2014 and 2015.

The licensee failed to ensure that resident #011 who was incontinent, received an assessment that include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence. [s. 51. (2) (a)]

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 ensuring that the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

Observation of resident #005 by inspector #519 revealed that the residents communication and response system (call bell) at the bedside did not activate a signal or sound when activated.

Inspector #519 reported the failed communication system to the Environmental Maintenance Manager who repaired the communication system immediately.

The Environmental Maintenance Manager confirmed that they rely on the the nursing staff to report issues with the communication system and that there was no schedule or procedure in place for routine preventative maintenance of the communication response system in the home.

The Environmental Maintenance Manager confirmed that there was no procedure in place for the routine preventative maintenance of bed systems, including bed rails, to ensure good repair and maintenance.

The Environmental Manager confirmed that it was the home's expectation that bed systems are part of an organized program for maintenance services.

The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair. [s. 90. (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 ensuring that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #7: 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 has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

During the tour of the home the following observations were noted in resident common areas:

Juniper home area:

The shower room had one white cabinet that had miscellaneous items such as an uncovered bed pan, soiled deflated air cushion, one unlabeled black comb with hair insitu, a soiled resident t-shirt in a toiletry drawer, and a soiled metal chair with an orange cloth seat.

Pine home area:

The shower area had one unlabeled round clear brush with hair insitu, a dried brown substance on the toilet seat and a similar dried brown substance on a wooden chair with a cloth seat.

The tub area had a white care cart with unlabeled soap, and nail clippers.

Chestnut home area:

The shower area had unlabeled hygiene items including a blue comb, and nail clippers.

The Infection Control Lead and Manager of Resident Care confirmed that it was the home's expectation that all personal care items were labeled with the residents name and that all staff participate in the implementation of the infection prevention and control program.

The white cabinet in Juniper shower area was removed and the bed bans were cleaned, covered, and stored when not in use. The two soiled chairs that were in the shower areas on Pine and Juniper were removed. [s. 229. (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 ensuring that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received fingernail care, including the cutting of fingernails.

Resident #011 was observed to have long dirty finger nails on two specified dates in 2015.

The plan of care for resident #011 under bathing indicated that the resident was to have fingernails manicured on bath day.

Review of the Point of Care record indicated the resident had been bathed one day prior to observation, with nail care completed and on two additional dates, including the second day of observation, with nail care refused.

Interview with the Manager of Resident Care and a Registered Practical Nurse confirmed that when the resident refuses care, the staff member should re-approach at another time. If the resident continues to refuse care, the Registered Practical Nurse would be notified and would attempt care. The RPN confirmed they were not aware that resident #011 had refused nail care.

The licensee failed to ensure that resident #011 received finger nail care, including the cutting of fingernails. [s. 35. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Minutes of the Residents' Council Meeting for a specified date in 2015 identified that members of the Council raised a concern related to the Environmental Department. No response to the concern was identified in the Residents' Council binder or in subsequent minutes of the Council.

Interview with the Administrator confirmed that a response was not included in the binder and that documentation failed to support that the drafted response had been shared with the Council.

The licensee failed to ensure that a response was provided in writing within ten days of receiving Residents' Council advise related to concerns or recommendations. [s. 57. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that improvements made through the quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents are communicated to the Residents' Council.

Review of the minutes of the Residents' Council Meetings from May 2014 to April 2015 and interview with the Administrator confirmed that the minutes did not contain quality improvements related to the accommodations, care, services and goods provided to the residents.

Interview with two members of the Residents' Council confirmed that quality improvements related to the accommodations, care, services and goods provided to the residents are not discussed during Residents' Council Meetings. [s. 228. 3.]

Issued on this 24th day of July, 2015

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

Original report signed by the inspector.