Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Dates of inspection/Date de l'inspection November 8, 9,10, 2010	**Inspection No/ d'inspection** 2010-155-2917-08Nov112200 2010-137-2917-08Nov112210	**Type of Inspection/Genre d'inspection** Follow up L-01682
Licensee/Titulaire Devonshire Erin Mills Inc., 195 Dufferin Avenue, Suite 800, London, ON N6A 1K7		
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 Inspectors/Nom de l'inspecteurs Marian C.Mac Donald #137, Sharon Perry #155		

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow up inspection.

During the course of the inspection, the inspectors spoke with: Administrator, DOC, registered staff, PSW's and residents.

During the course of the inspection, the inspectors: reviewed residents' health records, policies and procedures and conducted various walk-throughs of the Home Areas.

The following Inspection Protocols were used during this inspection: Skin & Wound Care, Minimizing of Restraining, Infection Control, and Personal Support Services.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

10 WN
9 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, s. 91
Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times.

Findings:

1. **On November 8, 9 & 10/10, the locking mechanism was malfunctioning on the Chestnut Home Area tub room door, allowing direct resident access to disinfectants and hazardous chemicals.**

Inspector ID #:	137 & 155

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, related to hazardous substances access, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007,c.8, s.(15)(2)(a)(c)
Every licensee of a long-term home shall ensure that
(a) the home, furnishings and equipment are kept clean and sanitary
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. **Observed the bases of sit-stand lifts on Pine, Chestnut, Juniper and Oak areas to be dirty.**
2. **Rubbermaid utility cart in tub room on Chestnut was observed to be dirty.**
3. **The sheepskin sling covers on Pine & Juniper home areas were observed to be worn and torn.**
4. **The foam handle grips, on the sit-stand lift on Juniper home area, were damaged.**

Inspector ID #:	137 & 155

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, related to equipment being kept clean and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 31(2)(2) **31(2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:** **(2) Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.**	
Findings: 1. **There is no documented evidence that alternatives to restraining were considered for three residents.**	
Inspector ID #:	137 & 155
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, related to ensuring restraint alternatives are considered, to be implemented voluntarily.	

WN #4: The Licensee has failed to comply with O. Reg. 79/10, s. 110(2)(6) **110(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:** **(6) That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, or at any other time when necessary based on the resident's condition or circumstances.**	
Findings: 1. **Oak Home Area – Between Nov.1-8/10, there were 48 missing registered staff initial entries on the restraint monitoring records, indicating that the need for restraint was not reassessed, at the end of each shift.** 2. **Pine Home Area – Between Nov.1-9/10, there were 10 missing registered staff initial entries on the restraint monitoring records, indicating that the need for restraint was not reassessed, at the end of each shift.** 3. **During the three days of inspection, registered staff were not observed evaluating or reassessing restraint use.**	
Inspector ID #:	137 & 155
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 related to restraint evaluation and reassessment by registered staff, to be implemented voluntarily.	

WN #5: The Licensee has failed to comply with O.Reg. 79/10, s. 110(7)3. 4. 6. **Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:** **3. The person who made the order, what device was ordered, and any instructions relating to the order** **4. Consent.** **6. All assessment, reassessment and monitoring, including the resident's response.**

Findings: 1. Eleven resident records, related to restraint use, were reviewed. 2. Consents and assessments for three residents were not current. 3. A residents' consent (July/06) not current and no documented evidence of assessment. 4. A residents' consent (June/06) and no documented evidence of assessment. No current physician order. Resident had been in hospital but restraint re-admission order was not obtained. 5. A residents' consent (Jan/06) not current and no documented evidence of assessment. The type of restraint identified on the consent is for a "back fastening seatbelt with pin lock". The physician order indicates "seatbelt for safety'. Care plan (Aids To Daily Living) indicates check client's safety devices; back fastening seat belt (every hour) and under Safety Devices/Restraints indicates trunk restraint and seat belt wheelchair. Resident was observed with a front Velcro fastening seatbelt, which they can undo.	
Inspector ID #:	137 & 155
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, related to restraint use, to be implemented voluntarily.	

WN #6: The Licensee has failed to comply with O. Reg. 79/10, s. 50(2)(b)(iv) **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,** **(iv) is reassessed at least weekly by a member of the registered staff, if clinically indicated;**	
Findings: 1. A resident with a chronic wound – last documented assessment is July 9/10 2. A resident with a Stage II ulcer – last documented assessment is Oct. 29/10. 3. A resident with a Stage III ulcer – last documented assessment is Aug. 14/10	
Inspector ID #:	137 & 155
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, related to weekly wound assessments, to be implemented voluntarily.	

WN #7: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 3(1)(11)(iv) **3(1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:** **(11)Every resident has the right to,** **(iv) have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in Accordance with the Act.**
Findings: 1. Daily report/communication binders, containing personal resident health information, were

readily accessible on each Home Area Desk, without staff supervision.
2. Life Lab reports were readily accessible, on Resident Home Area Desks, without staff supervision.
3. Resident chart access was readily available, in all Home Areas, without staff supervision.

Inspector ID #:	# 137 & 155

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, related to resident personal health information, to be implemented voluntarily.

WN #8 : The Licensee has failed to comply with O. Reg. 79/10, s. 37(1)(a)(b)
37(1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labeled within 48 hours of admission and of acquiring, in the case of new items; and
(b) cleaned as required.

Findings:
1. **Nov. 8/10 – Pine tub room – Hair brush & comb not labeled – dirty & imbedded with hair**
2. **Pine tub room – labeled hairbrush dirty & embedded with hair**
3. **Chestnut – Communal Stick deodorant & talcum powder – not labeled and used**
4. **Oak Tub Room – treatment cream not labeled.**

Inspector ID #:	# 137 & 155

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, related to infection control and labeling of personal items, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg. 79/10, s. 229(5)(a)
(5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

Findings:
1. **On November 8, 2010 , 2 PSWs and one RPN stated that they were not sure of the purpose or intended use of an infection control cart and signage that was in use.**

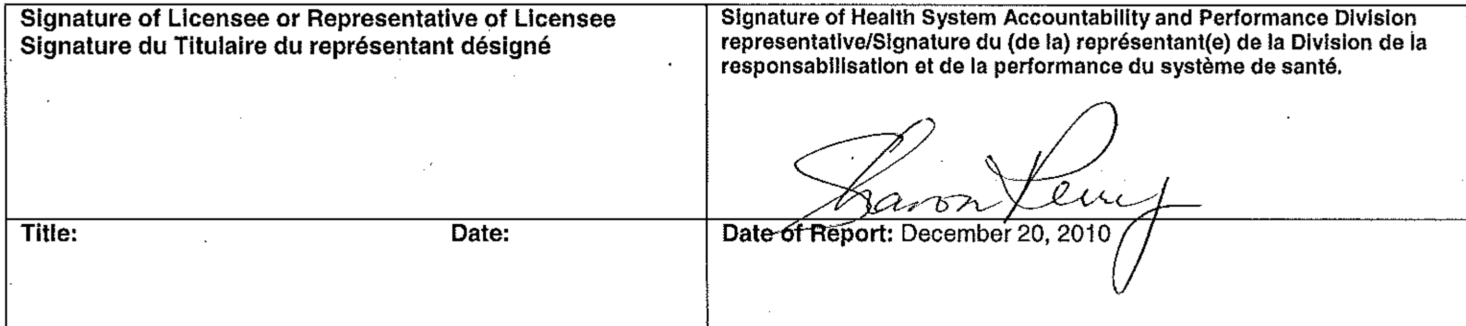
Inspector ID #:	155

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, related to monitoring symptoms indicating the presence of infection on every shift, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg. 79/10, s. 26(3)21
26(3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences

Findings: 1. Two residents' sleep patterns or preferences were not identified on their plan of care.

Inspector ID #:	155 & 137



Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** December 20, 2010