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 10, 2016	2016_276537_0004	000858-16	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (CHATHAM) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK NURSING HOME (CHATHAM)
110 Sandy Street CHATHAM ON N7L 4X3

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

NANCY SINCLAIR (537), CAROLEE MILLINER (144), TERRI DALY (115)

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): January 19, 20, 21, 22, 25 and 26, 2016.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co DOC), Staff Educator, Nutrition Manager, Volunteer and Family Services, Building Services, Activity Director, Restorative Care Assistant, Physio Assistant, Activity Aid, Housekeeping Aid, five Registered Nurses(RN), one Registered Practical Nurse(RPN), 13 Personal Support Workers(PSW), Residents' Council Representative, Family Council Representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified resident, policies and procedures, meeting minutes and observed the general maintenance, cleanliness and condition of the home.

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
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.

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

An identified resident had a fall.. Post fall, specific interventions for the prevention of further falls was requested by the Substitute Decision Maker (SDM). Observation of the resident, the room and interviews with Personal Support Workers (PSW's) #109, 110, 111 and 112 confirmed the requested interventions were implemented and in use by the resident.

Review of the resident's clinical record revealed the plan of care had not been reviewed and revised to include the specific interventions in use for falls prevention.

The Director of Care (DOC) #114 and Registered Practical Nurse (RPN) #106 confirmed the resident's plan of care should have been revised to include the additional fall intervention strategies. [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 the resident is reassessed and the plan of care is 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 be implemented voluntarily.

WN #2: 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 was complied with.

The home's policy titled "Resident Right, Care and Services - Required Programs - Falls Prevention and Management - Program" last revised November 11, 2014 stated the following:
"Registered staff will ensure that a resident who has a fall:
-Is the subject of immediate post fall huddle for completion of post fall work sheet including possible interventions;
-Has follow up progress notes completed for at least 3 shifts following the incident
-Is referred to restorative care and to physiotherapy and/or occupational therapy.
-Are assessed by physiotherapist within 7 days of post fall referral.
-Has high risk for falls communication logo attached to assistive device and placed at the

bedside"

A) Review of the clinical record for and identified resident indicated that the resident had a fall. There was a Fall Incident note completed but it did not include a summary of the post fall huddle. The clinical record also revealed that follow up progress notes were not completed for at least three shifts following the incident

Interview with Registered Practical Nurse #106 confirmed that there was to be follow up fall documentation for three shifts post fall as well as a post fall huddle completed and the results of the post fall huddle to be documented on the fall note in point click care as per the home's policy.

B) Review of the clinical record for and identified resident indicated that the resident had a fall.

A review of the post fall assessment in the progress notes revealed that staff documented that a Restorative/Physiotherapy referral was not applicable.

A review of the most recent assessments indicated the resident was a high risk to fall. A high risk for falls communication logo was not observed in use as per the policy.

An interview with the Co-Director of Care (Co-DOC) #113 revealed that the resident was not on the high risk indicator list as would be the expectation based on the results of the assessment, and therefore a high risk logo was not placed as expected.

The Co DOC #113 also confirmed that the home did not comply with their Falls Prevention and Management Program.

C) Review of the clinical record for and identified resident indicated that the resident had a fall. Review of the clinical record did not include documentation to confirm follow up progress notes were completed for at least three shifts following the fall, that there was a referral to restorative care and to physiotherapy and/or occupational therapy, or was assessed by the physiotherapist within seven days.

The Co DOC #113 and the DOC #114 verified that the required documentation, if completed, would be found in the computer documentation, and confirmed that post fall, the resident was not referred to physiotherapy, a physiotherapist assessment was not completed and post fall follow up documentation was not continued for three shifts.

The Co DOC #113 & DOC #114 also confirmed their expectation was that registered staff would follow the home's Fall Prevention and Management Program. [s. 8. (1) (a),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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that the lighting requirements set out in the lighting table were maintained.

The home was built prior to 2009 and is therefore subject to lighting requirements under the section of the lighting table titled "All Other Homes".

During Stage 1 Family Interview for resident #044, the interviewee indicated "The room is very dark. We have brought in lamps."

During Stage 1 Resident Observation it was noted that resident rooms and resident bathrooms in the home did not appear to have adequate lighting.

An interview with Administrator #116 revealed that the home was aware there might be some lighting issues and that lux readings were done corporately a few years ago, however a report of that assessment was not available.

The Building Services Supervisor #108 immediately replaced some of the bulbs with high efficiency LED bulbs which made a significant difference.

The home also obtained a Lux Meter. The Building Services Supervisor #108 conducted an assessment of lighting levels throughout the home on January 21, 2016, accompanied by the inspector.

All light fixtures were turned on if not already illuminated and allowed to warm up.

The home's Building Services Supervisor #108 used a hand held light/lux meter to obtain measurements.

Resident rooms in the North/East wings were equipped with a small over bed light with an upper and lower bulb.

Measurements were taken approximately three feet above and parallel to the floor by the head of the resident bed.

Three were three resident rooms where the lux was measured between 195 and 217.

The minimum required level is 376.73 lux at the bed of each resident when the bed is in the reading position.

Resident bathrooms in the North/East wings were equipped with a light mounted on the wall above the mirror with 2 bulbs.

Measurements were taken approximately three feet from the light source in front of the mirror and about the bathroom sink.

There were 6 resident bathrooms where the lux was measured between 133 and 190.

The minimum required level is 215.28 lux for all corridors and other areas of the home, not listed in the regulation which would include resident bathrooms.

The Administrator #116 and the Building Services Supervisor #108 acknowledged that some of the lux readings were below the regulation and that a full assessment of the home would need to be completed to address lighting requirements. [s. 18.]

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 lighting requirements set out in the Table to this section are maintained, 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, had been reassessed at least weekly by a member of the registered nursing staff.

The home's policy titled "Skin and Wound Care -Program effective September 16, 2013, stated the following:
"Registered Staff
4. Will ensure that in addition, a resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds;
-Has a completed wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status."

A) An identified resident had areas of altered skin integrity.

A review of the weekly assessments documented in the progress notes revealed weekly assessments had not always been completed.

The notes were also not consistently done for each of the areas of altered skin integrity.

A review of the treatment records also revealed a physician's order that a note for the

identified areas was to be done every day shift every Thursday.

An interview with the Registered Nurse #125 confirmed that weekly notes were completed for areas of altered skin integrity weekly in Point Click Care progress notes.

The Director of Care #114 indicated the expectation was that areas of altered skin integrity required weekly assessments to be documented in the progress notes, per the home's policy.

B) An identified resident was noted to have areas of altered skin integrity. Review of the resident's clinical record revealed weekly assessments were not completed. Registered Nurses #125 and #130 confirmed the assessments were not completed weekly as required.

The Director of Care #114 concurred it was the expectation of the home that resident's exhibiting altered skin integrity, would have the areas of impairment reassessed weekly by a member of the registered nursing staff and the findings documented in the clinical record. [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 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, to be implemented voluntarily.

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.