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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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 29, 2016	2016_419658_0002	019687-16	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

THE MEADOWS
12 TRANQUILITY AVENUE ANCASTER ON L9G 5C2

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

NEIL KIKUTA (658), ANN POGUE (636), JANETM EVANS (659), LALEH NEWELL (147), SHERRI COOK (633), YULIYA FEDOTOVA (632)

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 11, 12, 13, 14, 15, 18, 19, 20, 21, and 22, 2016.

The following intakes were completed within this Resident Quality Inspection:
Critical Incident log #005168-16, CIS #2844-000010-16, related to alleged staff to resident abuse;
Critical Incident log #020450-16, CIS #2844-000020-16, related to responsive behaviours; and
Complaint log #021014-16, IL-45671-HA, related to responsive behaviours and short staffing.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Food Service Manager, the Resident Staff Coordinator, the Environmental Service Supervisor, the Resident Assessment Instrument Coordinator, the Program Manager, the Physiotherapist, the Staff Coordinator, four Registered Nurses, five Registered Practical Nurses, three dietary aides, one laundry staff, 16 Personal Support Workers, five family members, the Family Council and Residents' Council Representative, and over 40 residents.

The inspector(s) conducted a tour of the home, and reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, Residents' and Family Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, meal and snack services, medication administration and storage areas, and required Ministry of Health and Long-Term Care postings.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
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
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

A) On July 15, 2016, a medication cart that contained resident medications was observed to be unattended and unlocked in the corridor on a resident home area.

On July 15, 2016, Registered Practical Nurse (RPN) #127 stated that the medication cart was to be locked when left unattended.

On July 19, 2016, Director of Care (DOC) #102 explained the home's expectations of staff locking the medication cart. The DOC #102 stated that the medication cart is to be kept locked when not in use or left unattended by registered staff.

B) On July 11, 2016, a medication cart that contained resident medications was observed to be left unattended and unlocked in the corridor on a resident home area. At the time of observation, there was one resident seated on their walker in the hallway not too far away from the medication cart.

On July 11, 2016, Registered Nurse (RN) #137 acknowledged that the medication cart was left unattended and unlocked. RN #137 stated that the medication cart should be locked and secured when not in use or unattended.

On July 19, 2016, Director of Care (DOC) #102 outlined the expectations related to the storage of medications and handling of the medication cart. The DOC #102 stated that the expectation was that medications were stored in the medication cart, and that registered staff were expected to ensure that the cart was kept locked when not in use or unattended. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

On July 11, 2016, a medication cart that contained resident medications was observed to be unattended and unlocked in the hallway of a resident home area. The narcotic and controlled substances box within the cart was found to be unlocked. At the time of observation, there was one resident seated on their walker in the hallway not too far away from the medication cart.

On July 11, 2016, Registered Nurse (RN) #137 acknowledged that the medication cart and controlled substances box were left unattended and unlocked. RN #137 stated that the controlled substances box should be locked and secured when not in use or left unattended.

On July 19, 2016, Director of Care (DOC) #102 outlined the expectations related to the storage of controlled substances. The DOC #102 stated that the expectation was that controlled substances were to be kept locked within the locked medication cart by registered staff when not in use or left unattended. [s. 129. (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 drugs are stored in a medication cart that is secure and locked, and that controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #2: 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.

As part of the home's infection prevention and control program, staff were required to follow their Routine Practices and Additional Precautions policy related to personal protective equipment.

On a specified date, signage was observed on the door of resident #004. Personal Support Worker (PSW) #132 entered the room of resident #004 to provide care, and they failed to follow the signage on the door. PSW #132 acknowledged that they had not followed the signage when providing direct care, and stated that they should have. The current care plan of resident #004 indicated that staff were to follow instructions as per signage on door when providing direct care.

During an interview with the Registered Nurse (RN) #103 and Director of Care (DOC) #102, it was stated that staff were expected to follow the posted signage for resident #004 when providing direct care. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

As part of the home's infection prevention and control program, staff were required to follow their Routine Practices and Additional Precautions policy related to hand hygiene.

A) On a specified date, a meal was observed in a specified dining room. During this meal, PSW #111 failed to wash their hands between clearing the dirty dishes in the dining room, and serving food to the residents. PSW #111 acknowledged to that they had not performed hand hygiene, and that they should have in between serving and clearing tables.

On July 19, 2016, DOC #102 stated that it was the home's expectation that staff wash

their hands at the start of the meal service, after handling dirty dishes, and between each resident.

B) On a specified date, a medication administration pass was observed on a resident home area. Registered Practical Nurses (RPN) #124 and #127 were observed dispensing medication and they failed to perform hand hygiene between resident care.

Interview with RN #103 and DOC #102 acknowledged that staff should be washing hands in between resident care and services. [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 to ensure that all staff participated in the implementation of infection prevention and control program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining service that provided

residents with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) On a specified date, resident #041 was served a meal in a specified dining room. Resident #041 waited until 15 minutes for encouragement to eat from PSW #104. Record review of the current care plan for resident #041 in Point Click Care (PCC), their Kardex, and the home's seating plan indicated that they required assistance with eating during meals.

B) On a specified date, resident #042 was served a meal in a specified dining room. Resident #042 was observed with their head down on the table with a meal and fluids for 11 minutes until PSW #123 assisted resident #042 to eat. Further observations of resident #042 over the course of 37 minutes indicated that resident #042 required assistance from PSW #123 to eat. Record review of the current care plan for resident #042 in PCC, their Kardex, and the home's seating plan indicated that they required assistance with eating during meals.

On July 14, 2016, interview with Director of Care (DOC) #102 acknowledged that residents assessed as requiring assistance to eat during meals required staff support to promote independence. [s. 73. (1) 9.]

2. The licensee has failed to ensure that residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required.

A) On a specified date, resident #044 was observed for 40 minutes with their meal and fluids on a table top in a specified dining room. After waiting 40 minutes, resident #044 was provided assistance by PSW #104. Record review of the current care plan for resident #044 in Point Click Care (PCC), their Kardex, and home's seating plan indicated that they required assistance with eating during meals.

B) On a specified date, in a specified dining room, resident #043 was observed for eight minutes with soup and fluids and no staff were seated to assist with the meal. Record review of the current care plan for resident #043 in Point Click Care (PCC), their Kardex, and home's seating plan indicated that they required assistance with eating during meals.

On July 14, 2016, Registered Nurse (RN) #103 and Director of Care (DOC) #102

acknowledged that residents requiring assistance for meals should not have a meal in front of them until staff were available to provide assistance. [s. 73. (2) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

During Stage I of the Resident Quality Inspection on July 13, 2016, residents #005, #006, and #008 reported missing personal clothing, and they all indicated that they had notified a staff member of their missing clothing.

On July 18, 2016, residents #005, #006, and #008 reaffirmed that their missing personal clothing items remained missing.

Interviews with staff members showed a lack of consistency with the reporting process of missing clothing. On July 13, 2016, PSW #111 stated that missing clothing gets reported to the nurse. On July 14, 2016, PSW #114 stated that missing clothing gets reported to the nurse, and then someone will print the missing laundry checklist to fill out. On July

15, 2016, PSW #123 stated that missing clothing gets reported to the nurse, and that a missing clothing checklist is not usually filled out. On July 18, 2016, laundry staff #113 stated that nursing staff had verbally reported missing personal clothing items for residents #006 and #008. Laundry staff #113 was unaware if a missing clothing checklist had been completed for residents #006 or #008, and did not know if the clothing had been located yet.

On July 13 and 18, 2016, the Resident Staff Co-ordinator #110 stated that the staff would report missing clothing by filling out a missing clothing sheet located on each unit. If staff call or email regarding missing clothing, Resident Staff Co-ordinator #110 would fill out a sheet as documentation. Their expectation was that staff receiving a missing clothing complaint was to fill out either a missing clothing checklist or client service response form.

Review of the complaint management program binder provided by the Resident Staff Co-ordinator #110 indicated no documentation of missing clothing of residents #005, #006, or #008.

Review of policy ES D-20-30 regarding Personal Clothing Procedures, Storage of Lost/Unclaimed Personal Clothing, with a revised date of November 20, 2012, stated that all lost clothing concerns are brought to the Resident Services Co-ordinator #110 who will complete a client service response or missing clothing checklist. Either form will be forwarded to the nursing and laundry departments to search for the missing clothing, and to report back to the Resident Service Co-ordinator #110. The missing clothing checklist and client service response forms provided for documenting actions and outcomes, and are to be completed and signed off by the Executive Director #101.
On July 14, 2016, the Environmental Service Supervisor #121 indicated that staff were required to fill out a missing clothing checklist and report it to the Resident Staff Co-ordinator #110.

The Executive Director (ED) #101 on July 18, 2016, clarified that there was a policy and process in place for missing clothing. It was stated that all forms are returned to the ED #101 for sign off and filing. The ED #101 acknowledged that the process was not being followed, and that the procedure to report and locate residents' lost clothing and personal items had not been properly implemented in the home. [s. 89. (1) (a) (iv)]

Issued on this 15th day of August, 2016

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

Original report signed by the inspector.