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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 18, 2014	2014_188168_0004	H-000151-14	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

LISA VINK (168), CYNTHIA DITOMASSO (528), DARIA TRZOS (561), THERESA MCMILLAN (526)

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): February 5, 6, 7, 10, 11, 12, and 13, 2014.

Please note this inspection report includes Complaint Inspection, log number H-000164-14, completed concurrently with the Resident Quality Inspection (RQI).

A dietary inspector will complete an Other Inspection, log number # H-000181-14, for Food Quality and Nutrition and Hydration Inspection Protocols which were triggered as a result of stage 1 of the RQI process, however not inspected during stage 2 of this RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Services Coordinator (RSC), Environmental Services Supervisor (ESS), Program Manager and recreational staff, Resident Assessment Instrument (RAI) Coordinator, Continuous Quality Improvement (CQI) Registered Practical Nurses (RPN), Physiotherapist, housekeeping and laundry staff, Registered Nurses (RN's), Personal Support Workers (PSW's), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services, reviewed documents including but not limited to: clinical health records, policies and procedures, and meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
 i. participate fully in the development, implementation, review and revision of his or her plan of care,
 ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
 iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
 iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family

and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
 i. the Residents' Council,
 ii. the Family Council,
 iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
 iv. staff members,
 v. government officials,
 vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the resident was afforded privacy in treatment and in caring for their personal needs.

On February 11, 2014, during the noon medication pass registered staff administered eye drops to resident #101 and nasal spray to resident #100 in the dining room. The registered staff and DOC confirmed that it was the home's expectation that eye drops, nasal sprays, capillary blood glucose readings and injections were not to be administered in the dining areas. [s. 3. (1)]

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 residents have the right to be afforded privacy in treatment and in caring for their personal needs, to be implemented voluntarily.

WN #2: 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 did not ensure that a written plan of care for the resident set out the planned care for the resident.

A. Resident's #560 bed was observed against the wall in the bedroom. The "Side Rail and Alternative Equipment Decision Tree" identified the resident was to have the bed placed against the wall. The tool indicated that a bed placed against the wall was considered a side rail. The plan of care, reviewed on February 07, 2014, did not include the placement of the resident's bed. Registered staff confirmed on February 11, 2014, that the bed placement should have been included in the plan of care and revised the plan.
B. Resident #652 was noted by staff to have a skin tear in January 2014 and a second lesion in January 2014. The current plan of care with target completion date of January 3, 2014, did not include the planned care for the resident specifically

related to the areas of altered skin integrity. [s. 6. (1) (a)]

2. Not all staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Resident #575 was identified as a high fall risk. The Minimum Data Set (MDS) assessment dated July 12, 2013, identified that the resident had a fall in the past 30 days. The MDS Resident Assessment Protocol (RAP), which was based on the MDS assessment and signed on August 20, 2013, identified that the resident had no falls since the previous assessment. The RAI coordinator confirmed that the assessments were not consistent with each other regarding the residents falls. [s. 6. (4) (a)]

3. The licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

A. On February 7, 2014, the plan of care for resident #549 indicated that staff were to administer mouthwash according the the Medication Administration Record. Mouthwash was prescribed by the physician in April 2013, and then discontinued in November 2013. Registered staff confirmed effective November 2013, the mouthwash was no longer administered to the resident and that the plan of care was not revised to reflect the change in care needs.
B. In September 2012, resident #609 was assessed as a high risk for falls. As a result of multiple falls with injury, staff initiated a bed alarm in July 2013. From July 2013, until February 14, 2014, the plan of care was not revised to include the use of the bed alarm as a safety intervention. Registered staff confirmed the use of the alarm as an ongoing safety intervention for the resident, and that the plan of care was not revised with this change in need. [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 that a written plan of care for the resident sets out the planned care for the resident and to ensure that the residents are reassessed and the plan of care reviewed and revised at any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: 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 did not ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place was complied with.

A. The home had a "Fall Interventions Risk Management (FIRM) Program, LTC-E-60, revised April 2013" and in use in May 2012, until approximately December 2013, which directed staff regarding the reassessment of residents in relation to fall risk and post fall activities. The policy indicated:
* "resident risk for falls and need for falling star logo will be reassessed quarterly and annually based on high/immediate risk criteria"
* that the Falls Risk Assessment Tool (FRAT) was to be completed on admission, with significant change, and quarterly for residents who are identified as high-risk
* that after a witnessed fall "a complete assessment with be completed including vital signs every shift for 72 hours. Findings will be documented in the interdisciplinary progress notes".

i. Resident #575 was last assessed as a high falls risk in May 2012, using the FRAT. The resident was not reassessed since this time to determine fall risk or the need for a falling star logo, as confirmed by the RAI coordinator. Interview with the DOC confirmed that the resident should have had a FRAT completed on a quarterly basis from May 2012, until December 2013, to determine fall risk level. The resident sustained a witnessed fall in June 2013. A review of the progress notes identified that staff did not consistently complete an assessment of the resident or vital signs every shift for 72 hours, as required in the policy.
ii. In 2013, resident #549 had an unwitnessed fall resulting in an injury. The resident was transferred to hospital for treatment and was admitted to the hospital before returning to the home. A FRAT was not completed, when the resident returned to the home post treatment. The DOC confirmed that the FRAT should have been completed by staff upon return to the home as the resident had a significant change in condition.
iii. Resident #609 sustained multiple falls. A review of the clinical record did not include post falls shift assessments documented for 72 hours, as required for incidents which occurred in August 2013, and February 2014, which was confirmed by the DOC.
B. The home's "Skin and Wound Care Program, LTC-E-90, revision date August 2012" indicated that "unregulated care providers would report any skin concerns to the Nurse/OT/PT or other qualified professional and would document/report every shift any identified skin condition changes to the Nurse".
i. Resident #652's progress notes and Treatment Administration Records indicated that they were assessed and treated for a skin tear effective January 2104, and a lesion effective January 2014, until present day. PSW Point of Care (POC) documentation of resident's skin condition between January 9, 2014, and February 7, 2014, indicated "none of the above observed" when referring to skin as scratched, red area, discoloration, skin tear, and open area. PSW staff confirmed that they did not document according to the policy related to the resident's skin integrity.
C. The home had procedures regarding "Personal Clothing, Storage of Lost/Unclaimed Personal Clothing, ES D-20-30" which stated that "all lost clothing concerns are brought to the resident services coordinator (RSC). The RSC will complete a client service response and forward the response to the nursing and laundry departments". On February 6, 2014, resident #620 communicated to the inspector a missing jacket, which was reported to staff. Registered staff confirmed that they were aware of the resident's concern related the jacket. Interviewed the RSC identified they were unaware of the missing jacket and confirmed that there was no client service response form completed. On February 11, 2014, the jacket was located in the laundry room, was labelled and returned to the resident. [s. 8. (1)]

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, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home, furnishing and equipment were maintained in a safe condition and in a good state of repair.

A. Not all wooden surfaces in the home and furnishings were maintained in a good state of repair. On February 5, 2014, it was noted that a number of wooden surfaces throughout the home were worn.
i. The finish on a number of wooden handrails were observed to be worn, leaving raw wood exposed with rough edges and cracks. The wearing was more prevalent in high traffic areas by elevators and dining rooms.
ii. The finish on a number of wooden wall base boards in the home were noted to be worn leaving raw wood exposed. This wearing was more prevalent in the resident dining areas.
iii. Wooden surfaces on approximately half of the resident dining tables and the legs of dining room chairs were noted to be worn with rough raw wood exposed.
iv. The ESS confirmed that the wooden fixtures identified were worn and in need of repair. The ED confirmed that the identified wooden fixtures and furnishings were worn and outlined future plans to repair the surfaces.
B. Not all call bells, which were part of the communication and response system were maintained in a good state of repair.
i. On February 6, 2014, when attempting to activate the bathroom call bell for resident #652, the pull cord broke away from wall unit. The resident was unable to use the call bell as a result. PSW staff were alerted and provided assistance to the resident as well as communicated the concern to the appropriate staff who fixed the cord.
ii. On February 6, 2014, the call bell for resident #666 was not in full working order at the bedside. The call bell was on a "y" connection to a chair alarm. The bell would not activate when pressed at the bedside. Direct care staff confirmed that the bell was not functioning properly and communicated the concern to the appropriate staff who fixed the concern.
iii. On February 7, 2014, the call bell in the bathroom for resident #640 was observed to be in disrepair. The handle was missing from the pull cord. PSW staff confirmed that the call bell was in disrepair and completed a log for repair. [s. 15. (2) (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 to ensure that the home, furnishing and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

The home had a "Resident Non-Abuse Policy, LP-C-20_ON, re-indexed March 2013". This policy provided direction to staff in the event of actual or alleged reports of abuse or neglect. The "Mandatory Reporting" section of this policy required "any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the home or, if unavailable, to the most senior supervisor on shift at that time". The "Immediate Interventions following Allegations of Resident Abuse" section of this policy identified "the first priority is to ensure the safety and comfort of the abuse victim(s), first taking all reasonable steps to provide for their immediate safety and well being, then through completion of full assessment, a determination of the resident's needs and a documented plan to meet those needs". The "Investigation" section of this policy indicated that "an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse or neglect will be initiated by the home's ED/designate".

Resident #641 made a report of rough care resulting in pain to two separate registered staff in 2013. This allegation of abuse was not managed as per the home's "Resident Non-Abuse Policy". The registered staff did not immediately reported the allegation to the ED or designate of the home. The ED confirmed that the incident was not immediately reported, and was not investigated until two days later, when it was identified it in the progress notes. A review of the clinical record did not contain an assessment of the resident for pain or injury until assessed by the physiotherapy department three days later, when a request was made by the DOC. [s. 20. (1)]

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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: 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 did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wounds.

Resident #652 was assessed in January 2014, as having an altered area of skin integrity, which was noted on one occasion to have purulent discharge. A clinically appropriate assessment instrument was not used by registered staff to assess the area. Registered staff confirmed that a Treatment Observation Record (TOR) was not implemented, as staff did not identify the area as "open". [s. 50. (2) (b) (i)]

2. The licensee did not ensure that, the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Resident #400 had pressure ulcers identified, in September 2013, at which time a dietary notification was completed, according to progress notes and staff interview. The areas had resolved the following month and the resident's skin was intact. The area reopened in November 2013, and was assessed as resolved that same month. A pressure ulcer was identified near the initial area of skin breakdown in December 2013. An assessment was completed for this area of altered skin integrity on January 22, 2014, by the registered dietitian (RD). The RD did not complete an assessment of the resident with altered skin integrity when the area was first identified in September 2013, or when it reopened in November 2013, as confirmed by the DOC during a clinical record review. [s. 50. (2) (b) (iii)]

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 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, to be implemented voluntarily.

WN #7: 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 did not ensure that drugs were stored in a medication cart that was secure and locked.

The noon medication pass was observed on February 11, 2014, from 1145 hours until 1230 hours. It was noted that the registered staff left the medication cart unlocked and unattended in the hallway at 1150 hours and went to the medication room. The cart was also observed unlocked when parked by the dining room at all times during medication pass, even when the nurse left the cart to administer medications in the dining area to residents. The cart was not consistently in the line of sight of the registered staff member when in the dining area. The staff member indicated that the cart was left unlocked during the medication pass as it was easier not to use the key every time medications had to be taken out of the cart. [s. 129. (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 to ensure that drugs are stored in a medication cart that is secure and locked, to be implemented voluntarily.

WN #8: 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 did not ensure that all staff participated in the implementation of the infection prevention and control program.

A. The home's policy "Routine Practices and Additional Precautions, IPC-B-10, last revised November 2013" required staff to follow routine practices related to hand hygiene and indicated that "all staff will perform hand hygiene before, between and after activities that may result in cross-contamination".
i. On February 5, 2014, staff in the dining room were observed serving plated meals while at the same time as handling dirty dishes used by other residents. At the completion of the meal staff were observed handling two clean wash cloths and simultaneously, washing two resident's faces, without exhibiting hand hygiene between the residents.
ii. On February 11, 2014, between 1145 hours and 1230 hours registered staff did not consistently wash or sanitize hands between the handling and administration of medications, including when physical contact with residents and medications was required.
iii. On February 11, 2014, between 1200 hours and 1300 hours staff did not consistently perform hand hygiene in the dining room. Staff were observed to assist in the feeding a resident, followed by serving coffee to various residents, and then assisted to feed another resident, without performing hand hygiene.
B. The "Pets-Visiting and Resident policy, IPC-M-10, effective July 2013", identified that "owners and handlers shall be responsible for maintaining up to date veterinarian and vaccination records while their pet/animal visit the Home. Veterinary documents will be provided to the Home by animal owners to verify up to date check-ups and vaccinations as required by regional/provincial jurisdictions". A frequent visitor who brought a dog to the home and the DOC confirmed that the home did not request the copy of vaccination records from pet owners, that verbal confirmation only was obtained. It was identified by the DOC that regular pet therapy, as part of the recreational program, were required to provide the necessary documentation. [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 the infection prevention and control program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a Personal Assistance Services Device (PASD) described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the resident's plan of care.

Resident #575 was observed during the inspection to be using a front fastening seat belt. The resident was able to unfasten the belt on demand and the device was identified to be a PASD. The belt was not included in the resident's plan of care when reviewed on February 11, 2014. Interview with registered staff confirmed that the belt should have been included in the plan. [s. 33. (3)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records

Every licensee of a long-term care home shall ensure that,

(a) a written record is created and maintained for each resident of the home; and

(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee did not ensure that, a written record was maintained for each resident and was kept up to date at all times.

Resident #400 had an area of altered skin integrity identified in September 2014, and an "Initial Wound Assessment" form was initiated as required. The clinical record was reviewed and the home was unable to produce the Treatment Observation Records (TOR's) for the weekly skin assessments for this area of altered skin integrity from September 2013 until October 2013, which was confirmed by the DOC. [s. 231. (a)]

Issued on this 18th day of February, 2014

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

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