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 12, 2016	2016_356618_0001	000623-16	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

OAK TERRACE
291 MISSISSAGA STREET WEST ORILLIA ON L3V 3B9

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

CECILIA FULTON (618), JOELLE TAILLEFER (211), SHIHANA RUMZI (604)

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 12,13,14,15,18,19,20,21,22, 2016

The following Critical Incidents: #001955-15, 011455-15 and the following complaints #00150-16, 000193-14 were inspected during the course of this RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Director of Dietary Services, Environmental Services Manager (ESM), Recreation Services Manager, Staff Educator/Quality Manager, RAI/MDS Co-ordinator, Nutrition Manager (NM), Registered Dietitian (RD), Physiotherapist (PT), Program Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, Physician, residents and family members.

During the course of the inspection, the Inspectors conducted observations of residents and home areas, medication administration, meal service delivery, staff to resident interactions, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council, minutes of relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

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
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **10 WN(s)**
- **3 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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During stage one resident observations, the inspector witnessed two residents mattresses sliding off the bed.

The home had conducted a "Bed Assessment" audit through Joerns on May 7, 2015, which identified the two above mentioned beds as not having mattress keepers in addition to 29 other beds.

Interviews with the Executive Director (ED) and Environmental Services Manager (ESM) confirmed that the 31 beds identified in the audit did not have mattress keepers and posed a safety risk to the residents.

When the inspector brought this issue to the attention of the home, the home implemented a plan to address the issue. [s. 5.] (604) [s. 5.]

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 is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

On January 19, 2016, the inspectors felt that the air temperature in the hallway on the main floor was cold and at 1215 hours, inspector #618 observed thermometer readings

on the main floor hallway to be 19.6 degrees Celsius, and on the second floor hallway to be 20.3 degrees Celsius.

Review the home's Temperature Log sheet identified that the main floor hallway temperature was 21.3 degrees Celsius on January 18, 2016, during the evening and 18.3 degrees Celsius on January 19, 2016, during the day.

Review of the home's Temperature Log sheet identified that the second floor hallway temperature was 21.7 degrees Celsius on January 18, 2016, during the day, 21.2 degrees Celsius during the evening, and 20.9 degrees Celsius during the night.

Interviews with several residents revealed that the home air temperature felt cold in the hallways and their rooms during the evening of January 18th and during the day on January 19th, 2016.

Interview with the staff educator/quality manager (SE/QM) revealed that one resident had complained the home felt cold on January 19, 2016.

Interview with the environment services manager (ESM) revealed that they had been called on January 18, 2016, at 2200 hours and informed that the home air temperature was cold. The ESM revealed that they went to the home and determined the drop in air temperature was due to the draft coming out of elevator's shaft and gaps under the front doors.

Interview with ESM revealed that on January 19, 2016, blankets had been placed in front of the door gaps as a temporary measure to stop the cold air coming inside the home and that they had covered the roof top elevator vent to prevent cold air from flowing in.

The ESM, further revealed on January 20, 2016, the installation of permanent, rubber sweeps to all exterior doors was completed.

Interview with the ESM confirmed that the home's air temperature had been lower than 22 degrees Celsius on January 18 and 19, 2016.

Interview with the ED confirmed that the home is to be maintained at a minimum temperature of 22 degrees Celsius. [s. 21.]

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 is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #3: 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 an area or medication cart that is (i) used exclusively for drug and drug-related supplies and (ii) that is secure and locked.

a.) On January 12th and 21st, 2016, the inspector observed several residents' topical, prescription medications stored in a cupboard in the first floor and second floor tub rooms. These cupboards did have locking mechanisms however neither was in good repair and both could be opened with minimal effort. As well as that, the keys to open these cupboards were hanging by a chain on the outside of these cupboards.

These cupboards also contained a number of other non-drug related items including razors, soap, combs, baggies, paper products, and creams.

Interview and observation with the Staff Educator/Quality Manager (SE/QM) confirmed the Inspector's findings that the cupboards were not locked and that many other products were stored in these cupboards with the medications. The SE/QM was aware that this cupboard was used for the storage of topical prescription medications.

b.) On January 12, 2016, the Inspector observed an open container sitting on top of a treatment cart in the first floor tub room containing topical medications.

Medications found in this container were labelled, topical prescription medications for several residents.

SE/QM confirmed that these medications should not have been left where they were and should have been locked in the medication cupboard located in this tub room.

c.) On January 14, 2016, the Inspector observed an unlocked fridge in a back hallway on the first floor which contained six boxes of Influvac and three boxes of Fluad injectable medications.

The inspector's findings were verified by the DOC and the ED and confirmed the fridge should be locked. [s. 129. (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 drugs are stored in an area or medication cart that is (i) used exclusively for drug and drug-related supplies and (ii) that is secure and locked, to be implemented voluntarily.

WN #4: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the following are documented:

1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Review of the home's head to toe skin assessment dated November 6, 2015, indicated that one resident had impaired skin integrity.

Review of the resident's progress notes of November 11, 2015, indicated that an assessment of the skin was to be done every Wednesday.

Review of the physician order dated November 7, 2015, instructed the nurse to treat the area and to apply a dry dressing.

Interview with RPN #118 revealed they had assessed the resident's skin on the following week and they were healed, but they were unable to provide the documentation of the assessment.

Interview with the DOC confirmed the resident's skin should have been assessed at least weekly and the assessment should indicate when the wounds were resolved. [s. 6. (9)]

WN #5: 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 was complied with.

Observation of medication administration conducted on January 21, 2016, at 0830 hours, revealed the unit's narcotic and controlled sheet count did not correlate with the individual narcotic count for three residents.

The home's policy "Management of Narcotic Controlled Drugs/Benzodiazepines-Ontario" Index LTC-F-80- ON Standard operating Procedure #3 states:

Narcotic and controlled drug(s) are then documented on the Unit's Narcotic and Controlled Count Sheet and on the Individual Resident's Narcotic and Controlled Drug Count Sheet located in a separate binder and or on the Medication Administration Record (MAR) binder, which will be stored in the medication room when not in use.

Interview with RPN #115 and DOC confirmed that dispensed narcotics are to be signed off on the "Unit Narcotic and Controlled Drug Count Sheet" and that the count is to be carried over to the "Resident's Individual Narcotic and Controlled Drug Count Sheet" and confirmed the count was not carried out as per the home's policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

Observation of medication administration conducted on January 21, 2016, at 0830 hours, revealed the "Unit Narcotic and Controlled Drug Count Sheet" was not signed off by two registered staff during 0700 hour shift count.

The home's policy "Management of Narcotic and Controlled Drugs" Index: LTC-F-80: National Operating Procedure #7 indicates: Two Nurses, one from outgoing shift and one from incoming shift, will count and sign off on the Narcotic and Controlled Drug Count Form every shift change. When counting, narcotic vials and blister packs must be inspected to ensure accuracy.

Interview with RPN #115 and DOC confirmed there was no second nurse signature for shift count and that the home's expectation is to have two registered staff sign off the Narcotic and Controlled Drug Count Form". [s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of five Per cent of body weight, or more over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes are evaluated.

Review of one resident weight indicated the resident had a weight loss of greater than five Per cent from August 5, 2015 to September 1, 2015. Record review revealed a re-weigh was performed.

Review of nutrition intake records from August 2015 revealed that resident's intake was 50 to 100 Per cent at most meals.

Interview with the registered dietitian (RD) revealed the resident was not referred for weight loss and was not assessed by the RD or the FSM when the resident experienced weight loss which exceeded five Per cent in September 2015.

Interview with ED confirmed that this resident's weight change as recorded on September 1, 2015 should have been assessed by the RD or the FSM. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following:

1.All areas where drugs are stored shall be kept locked at all times, when not in use.

On January 15, 2016, at 0810 hours, the inspector observed an unattended medication cart located outside of the main dining room during breakfast service. The medication cart was unlocked and the inspector was able to open the drawers of the medication cart. Residents were in the vicinity of this cart.

Interviews with RPN #102 and the DOC confirmed that the medication cart was unlocked and its contents were accessible to anyone passing by and that the medication cart is to be kept locked at all times when not in use. [s. 130. 1.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

A resident returned from a hospitalization with medication orders from the hospital physician.

Medication reconciliation completed by the LTCH physician altered the medication orders for this resident.

A review of the Medication Administration Record System (MARS) for December 2015, revealed that the medications were not administered to the resident as prescribed.

Interview with RPN #105 and the DOC confirmed that the resident was not administered the medications as prescribed and that a medication error had occurred. [s. 131. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. 1. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with the residents, training in skin and wound care, at times or intervals provided for in the regulations.

Review of the skin and wound care training records and interview with the staff educator/quality manager (SE/QM) revealed that 15.8 Per cent of direct care staff had received skin and wound care training in 2014 and 90.3 Per cent in 2015. [s. 221. (1) 2.] (211) [s. 221. (1) 2.]

2. The licensee has failed to ensure that all staff who provides direct care to residents receives, as a condition of continuing to have contact with the residents, training in skin and wound care, at times or intervals provided for in the regulations.

Review of the skin and wound care record and interview with the staff educator/quality manager (SE/QM) indicated 15.8
Per cent of direct care staff received the skin and wound care training in 2014 and 90.3 Per cent in 2015. [s. 221. (1) 2.]

WN #10: 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 staff participates in the implementation of the infection prevention and control program.

During lunch meal observations on January 12, 2016, dietary staff #100 was observed clearing dirty dishes from table #11, emptying the dirty dishes in a bin and proceeding to portion out the ice cream bars in the kitchen without performing any hand hygiene between tasks.

Interview with dietary staff #100 confirmed they had not performed any hand hygiene between these tasks.

Interview with the Dietary Manager indicated kitchen staff are to carryout hand hygiene when going from handling dirty dishes to portioning out desserts and confirmed staff did not follow infection control protocols. [s. 229. (4)]

Issued on this 12th day of February, 2016

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

Original report signed by the inspector.