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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Apr 22, 2013	2013_201167_0011	H-000086-13	Complaint

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

RIDGEVIEW
385 HIGHLAND ROAD WEST, STONEY CREEK, ON, L8J-3X9

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

MARILYN TONE (167), CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): April 12, 15, 17 and 18, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered staff and personal support worker staff, the Food Services Supervisor and an identified resident.

During the course of the inspection, the inspector(s) conducted a review of the health records for the identified resident, reviewed relevant policies and procedures at the home, conducted a tour of selected home areas and observed care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry

Continence Care and Bowel Management

Falls Prevention

Nutrition and Hydration

Personal Support Services

Responsive Behaviours

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Resident # 001 did not receive a post-fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls when they continued to experience falls.

A) Resident # 001 sustained 10 falls over an specific time frame.
B) After each fall, progress notes were completed but no post-fall assessment using a clinically appropriate assessment instrument was completed to identify causative factors, evaluate the effectiveness of the plan of care or to look at other strategies that may be helpful to prevent further falls.
C) During interviews with the Director of Care and the Administrator, it was confirmed that no clinically appropriate instrument was used for the identified resident post fall.
[s. 49. (2)]

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 when a resident has fallen that the resident is assessed and where the condition or the circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #2: 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. Resident # 001 was not reassessed at least weekly by a member of the registered nursing staff when they developed altered skin integrity.

A) The progress notes for resident # 001 indicated that the resident developed altered skin integrity on an identified date.
B) On the following day, the progress notes indicated that the resident's dressing was intact but no assessment of the area was completed.
C) The progress note completed 11 days later indicated that the resident's dressing was changed but no assessment was completed.
D) The progress note completed three days later indicated that the area around the resident's altered skin integrity was red and appeared to be infected.
E) The progress notes completed one day later indicated that the resident was started on an antibiotic for the infected wound.
F) The progress notes the next day indicated that the resident's dressing was dry and intact but no assessment was completed.
G) Seven days later, the documentation on the back of the resident's treatment administration record indicated that the wound was healing well and treatment will continue for two weeks.
H) One day later, the progress notes indicated that the resident had finished their antibiotic and that the wound dressing was intact but no assessment was completed.
There was no other assessments completed to indicate the progress of the healing or when the wound was actually healed.

On an identified date, it was noted in the progress notes that the resident sustained a injury that caused altered skin integrity.
A)Two days later, the progress notes indicated that the dressing to the area was changed and an assessment of the resident's wound was done.
There were no further notes related to assessments completed to indicate the progress of healing or when the resident's altered skin integrity was actually healed.

Weekly assessments of resident # 001's altered skin integrity were not completed by a member of the registered nursing staff. [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 when residents exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds that the residents are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. Resident # 001 did not receive preventative foot care services to ensure comfort and to prevent infection.

A) Resident # 001 was admitted to the home in 2012 and the resident's power of Attorney (POA) signed a consent for foot care services by the foot care nurse in October 2012. This consent was found on the resident's health file.
B) The document that the home refers to as the care plan dated as initiated in 2012, indicated that the resident was to receive foot care by the foot care nurse.
C) A second consent for foot care services by the foot care nurse was signed by the resident's POA in January 2013.
D) The resident did not receive foot care by the foot care nurse until February 2013 after the resident's POA brought the need for foot care to the attention of the nursing staff.
E) The resident's POA reported that the resident was having pain related to foot issues. [s. 35. (1)]

WN #4: 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. Not all residents with the following weight changes were assessed using an interdisciplinary approach, and actions were not taken and outcomes were not evaluated:

A) A change of 5 per cent of body weight, or more, over one month
B) A change of 7.5 per cent of body weight, or more, over three months
C) A change of 10 per cent of body weight, or more, over six months
D) Any other weight change that compromises their health status
Resident # 001 had a weight change of 7.7 per cent over 3 months. This weight change of 5.5 kg was not assessed using an interdisciplinary approach and actions were not taken and outcomes evaluated. [s. 69.]

Issued on this 7th day of May, 2013

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

Marilyn Love