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

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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
Sep 29, 2014	2014_228172_0012	L-000695-14	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

RIVERBEND PLACE
650 CORONATION BLVD., CAMBRIDGE, ON, N1R-7S6

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

JOAN WOODLEY (172), DOROTHY GINTHER (568), MELODY GRAY (123), REBECCA DEWITTE (521), SHERRI GROULX (519)

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 28, 29, 30, August 5,6,7,9,11, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Nutritional Manager, the Registered Dietitian, the Activation Manager, the Environmental Manager, the Education Coordinator, 3 Registered Nurses, 1 Registered Practical Nurse, 7 Personal Support Workers, 2 Dietary Aides, 4 Environmental Service Workers, Residents and Family members.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas, and care provided to residents, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, minutes relevant to the inspection and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. 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 has failed to ensure that the home is a safe and secure environment for its residents.

Observations made during the initial tour of the home revealed:
a) a hot water dispenser and a large toaster in the Dining Room servery, located in an unlocked area were accessible to residents,

b) an unlocked Laundry Chute Room with an unlocked laundry chute large enough for a person to fall into.

Interview with the Executive Director(ED), revealed :
a) that the Laundry Chute Room have always been unlocked.
b) that the hot water dispenser and the toaster were accessible to residents in the servery and that the potential for residents to burn themselves was there.
c) the ED confirmed it is the home's expectation that residents will live in a safe environment. [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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in good repair.

Observations revealed:
a) A tear in the carpet approximately five centimeters in length in front of #228,
b) Peeling varnish, as well as wood has chipped on the handrails throughout the home,
c) The wooden door to the Hillside Lounge has a chipped area approximately ten centimeters in length at the lower left corner.
d) The electrical outlets at water cooler and in hallway were not aligned with gap in drywall and the face plate of outlet close to water cooler was cracked.
e) The laminate on the counter top in the Activity Room was chipped and partially missing at the edge.
f) Baseboards were not attached to the wall throughout the home including those on the dining room wall across from the fridge, and in the Activity room at the left corner of the exit door to secured outside area.

Interview with the Environmental Services Manager revealed the home will be completing maintenance audits on a more frequent basis to identify areas needing repair and repairs will be made as soon as possible.

Interview with the Executive Director confirmed the home was in need of repairs by maintenance, as it is the home's expectation that the home, its furnishings and equipment will be maintained in good 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, furnishings and equipment are maintained in a safe condition and in good repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Observations revealed:
Residents with one full rail, 1/4 rail in the up position, two half rails in the up position,with one three-quarter side rail in the up position and other variations.

Policy review of Bed Entrapment (ESP-B-65) dated March 2014, revealed that all bed systems will be evaluated annually (at a minimum) for zones of entrapment.

Interview with the Executive Director confirmed that bed systems in the home have not been evaluated since May of 2012 and the home's expectation is that annually bed systems in the home will be evaluated. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Observation of a Resident's bed revealed that one full rail was up on the right and one 1/4 rail was in place on the left. This Resident was observed resting in bed with the right full bed rail in the up position and the left 1/4 rail in place. The left rail was not secured to the bed frame but was fit under the mattress. The gap within the rail measured 12" x 12" posing potential for entrapment in zone 1.

The Bed Entrapment Checklist completed July 29, 2014 indicated that the side rails were secured to the bed frame. [s. 15. (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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness;

Observations in adining room, revealed:
a) In the fridge two trays of juice drinks in cups were stored without covers to prevent adulteration or contamination twice during the inspection.
b) The dessert trays arrived onto the Riverside dining room uncovered with an overall mesh cover that did not seal the food.

Interview with a Cook confirmed the cups and desserts were uncovered while being stored.
Interview with a Cook confirmed the home's expectation is that all items should be covered properly when stored in the fridge or when being transported. [s. 72. (3) (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 all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness, to be implemented voluntarily.

WN #5: 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 all staff participate in the infection prevention and control program.
Observations revealed:
a) carpets throughout the resident home area showed multiple stains
b) a soiled plastic disposable glove was lying on the floor of shared BR by the toilet
c) a blue plastic wash basin was sitting on the bathroom floor under sink
d) a blue plastic wash basin was sitting on the floor in the bathroom by the toilet and a metal measuring cup was sitting on the counter in the BR
e) a plastic slipper bedpan stored in floor under sink in shared bathroom
f) one blue slipper bed pan was observed on the floor of a shared bathroom
g) West wing spa room had an unlabeled comb, two nail clippers, deodorant, scissors, body lotions observed in West wing spa room on care cart and an unlabeled nail clipper was observed on the towel cart to right of tub
h) South wing spa unlabeled brush and razor observed in South Wing spa during tour. Items in plastic basin for cleaning without labels razor, tweezers, scissors, nail clippers. Bar of soap, deodorant, body spry talc unlabeled, unlabeled comb in the drawer of a wooden side table, an unlabeled bottle of lotion. There was also a body scrub puff hanging unlabeled on the tub. The tile was buckled on the floor with white water stains on the floor by the wall.
i) a hand sanitizer container in the dining room was empty and was confirmed by the Dietary Manager.(123)

Interview with the Director of Care and the Infection Control Lead confirmed that the home's expectation is that the blue slipper bed bans are stored in the residents bed side tables in ward rooms and at the back of toilet in private rooms. The residents' personal care items are to be labeled with a black magic marker and nail clippers are to be labeled with a labeling machine once removed from the supply area for residents. Also, that it is the home's expectation the the hand sanitizer containers are refilled by the housekeeping staff or the nursing staff when it is empty. [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 all staff participate in the implementation of the program, to be implemented voluntarily.

WN #6: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Observations in a dining room revealed a food service worker standing to feed a resident his/her soup.
Interview with the food service worker confirmed he/she was standing and that it is the homes expectation that staff sit to feed a resident for their safety. [s. 73. (1) 10.]

Issued on this 29th day of September, 2014

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