Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 2, 3, 6, Sep 29, 30, Oct 4, 2011	2011_053122_0001	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

ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

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

ROSE-MARIE FARWELL (122)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Care (DOC); Associate Director of Care (ADOC); Environmental Services Manager (ESM); Programs Manager; 2 nursing staff; 7 residents; 2 complainants.

During the course of the inspection, the inspector(s) Observed the overall condition, maintenance and cleanliness of the home, furnishings, resident rooms.
Observed the provision of care and services to the residents of the home.
Reviewed the archived health record of resident [redacted] deceased.
Reviewed the licensee's policies, protocols and procedures related to documentation, access to the residents plan of care, communication of changes in the residents' health status, communication of changes in health status to the POA, medication storage, infection control, maintenance and housekeeping.
Reviewed the home's communication tools for shift to shift report.
Reviewed the Health & Safety Committee minutes for May 25, 2011, March 16, 2011.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Personal Support Services

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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. During a walkthrough of the home on May 31, 2011 at 11:10 hrs, the Inspector made the following observations:

The walls in Public Washrooms A315 and A207 were heavily soiled and stained with accumulated dirt, soap and water stains. Further, an accumulation of dirt, dust and debris was observed along baseboards and corners of A315.

Numerous spills, accumulated dirt, dust and debris was observed in the following resident rooms and/or resident washrooms: 3113, 3117, 3211, 3215.

An empty cookie tray which contained orange peels was observed beside 1 resident's bed and a soiled vinyl glove was observed under the other resident's bed in room 3113.

A medication cup and several soiled tissues were observed under the bed in room 3114.

Smeared feces and/or urine was observed on the toilet seats, bowls, rims and/or bases in the following resident washrooms 3117, 2103, 1208, 3208, 3211, 3215, 3216.

The floors of the following resident washrooms were observed to be tacky, sticky or soiled with urine or feces: 3216, 3211, 3117, 2217.

A fall mat was observed heavily soiled with dirt in room 2201.

A resident's recliner was observed heavily soiled and stained with unknown substances in room 1215.

A strong odour of urine was noted in the resident washroom in room 2217. A strong, unidentified odour was noted in room 2103.

An accumulation of copious amounts of bird droppings on the 2nd floor balcony with shared access from off of the Celeste House and Primrose House dining rooms.

During a walkthrough of the home on June 2, 2011 at 9:29 hrs, the Inspector made the following observations:

Room 3114 a soiled catheter bag not completely emptied of contents and not rinsed was left in a basin on the floor beside the bed. Soiled tissues was observed under the bed.

Accumulated dust, dirt and debris was noted behind the entrance doors to rooms 3117, 3108, 3214. The floor of room 3117 was tacky and in need of mopping. The carpet in room 3216 was littered with debris and had not been vacuumed.

Smeared feces and/or urine observed on the toilet seats, bowls, rims and/or bases in the following resident rooms: 3211, 3215, 3201, 3216.

The licensee failed to to ensure that procedures were developed and implemented for cleaning of the home including: floors, carpets, furnishings, contact surfaces and wall surfaces in resident bedrooms, common areas and staff areas. The licensee failed to ensure that procedures were developed and implemented for the removal and safe disposal of dry and wet garbage. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.
[LTCHA 2007, O. Reg. 79/10, s. 87. (2) (a) (c) (d)]].

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 procedures are developed and implemented for, cleaning of the home including resident bedrooms, common areas and staff areas including: floors, carpets, furnishings, contact surfaces and wall surfaces; to ensure that procedures are developed and implemented for the removal and safe disposal of dry and wet garbage and to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours, 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 subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Findings/Faits saillants :

1. During a walkthrough of the home on May 31,2011, the Inspector observed copious amounts of accumulated bird droppings on the second floor balcony with shared access from the Celeste House and Primrose House dining rooms.

During the course of the inspection, the Inspector reviewed the minutes of the March 2011 and May 2011 Health & Safety Committee meetings and noted that the accumulation of bird droppings on the 2nd floor balcony with shared access from the Celeste and Primrose dining rooms was brought to the attention of the licensee at the March 16, 2011 meeting and was noted to be unresolved and discussed again during the May 25, 2011 meeting.

The licensee failed to ensure that there is an interdisciplinary team approach in the co-ordination and implementation of the infection control program.
[LTCHA 2007, O. Reg. 79/10, s. 229 (2) a].

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. During the course of the inspection, the Inspector spoke with the resident's POA who reported that she was first notified of a change in the resident's health status on the afternoon of March 29, 2011 at which time the home sought her consent for the resident's transfer to hospital to have a ring cut off. The POA attended the home later that evening and discovered that the home had been aware of the resident's altered skin integrity since March 26, 2011 but failed to notify her in a timely manner and failed to treat the resident's altered skin integrity for 4 days.

On June 2, 2011, the Inspector reviewed the Day Book located at the nursing station of the resident's home area and observed an entry which stated that the fingers of the resident's left hand were swollen. The entry was dated March 26, 2011.

On June 2, 2011, the Inspector reviewed the resident's health electronic and archived health record and found no documentation pertaining to altered skin integrity, as noted in the unit Day Book on March 26, 2011.

The licensee failed to ensure that a resident exhibiting altered skin integrity, received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required. [O. Reg. 79/10, s. 50 (2) (b) (ii)].

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 resident exhibiting altered skin integrity, receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection as required, 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 subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. On June 2, 2011, the Inspector reviewed the Day Book located at the nursing station of the resident's home area. The Inspector observed an entry dated March 26, 2011, which stated that the fingers of the resident's left hand were swollen.

The Inspector reviewed the resident's electronic and archived health record and found no documentation pertaining to altered skin integrity as noted in the unit Day Book on March 26, 2011.

The licensee failed to ensure that the resident's plan of care was revised to reflect the resident's altered skin integrity identified on March 26, 2011 and noted in the unit Day Book.
[LTCHA 2007, S.O. c. 8, s. 6 (10) b].

2. On June 2, 2011, the Inspector reviewed the unit Day Book located at the nursing station of the resident's home area and observed an entry dated March 26, 2011, which identified that the fingers of the resident's left hand were swollen.

The Inspector also reviewed the resident's electronic and archived health record and noted that it did not contain any information pertaining to the swollen fingers of the resident's left hand, as noted in the unit Day Book on March 26, 2011.

On June 2, 2011, the Inspector noted an entry in the unit Day Book dated March 29, 2011 which stated "daughter in spoke with RN see NN". The Inspector reviewed the electronic progress notes and observed an entry dated March 29, 2011, which stated that the resident's POA had come in to visit the resident and expressed great concern regarding the bruising and swelling to resident's finger.

During the course of the inspection, the Inspector reviewed the resident's archived health record and observed 3, separate pages scattered throughout the resident's plan of care which stated "ATTENTION STAFF: PLEASE INFORM DAUGHTER OF ANY NEW ORDERS OR CHANGES IN (resident's name) HEALTH. SHE CAN BE CONTACTED AT ANY TIME OF THE DAY OR NIGHT."

During the course of the inspection, the Inspector spoke the resident's POA/SDM. The POA reported that she was not notified of the resident's altered skin integrity until March 29, 2011, 4 days after the swollen fingers were noted by staff.

The licensee failed to ensure that the resident's substitute decision maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care. [LTCHA 2007, S. O., c.8, s. 6 (5)].

Issued on this 4th day of October, 2011

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