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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 19, 20, Oct 7, Nov 8, 24, 2011	2011_027192_0038	Complaint

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

Long-Term Care Home/Foyer de soins de longue durée

ORCHARD TERRACE CARE CENTRE
199 GLOVER ROAD, STONEY CREEK, ON, L8E-5J2

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

DEBORA SAVILLE (192)

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, Registered Nurse, Registered Practical Nurses, Personal Support Workers, Dietary Staff, Recreation staff and residents related to H-001391-11

During the course of the inspection, the inspector(s) reviewed medical records, incident reports, policy and procedure, and observed care provided.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Nutrition and Hydration

Pain

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. 6. Plan of care

Specifically failed to comply with the following subsections:

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
(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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. A specified resident is identified by nursing to have alterations in skin integrity and skin fragility. The assessment completed by the dietitian indicates that skin is intact. Interventions in place do not address the risk of skin breakdown for the resident.
2. The licensee has failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan of care. The plan of care for a specified resident indicates that the consistency of fluids are to be altered. The resident was observed to be unsupervised while drinking coffee for which the consistency was not appropriate based on direction in the plan of care. Staff interviewed indicated that the resident is left unattended with the call bell in reach during nourishment and indicated that the coffee consistency was incorrect. During the observation period on September 19, 2011 the resident choked on fluids served on three occasions. No staff member was in attendance to supervisor or assist the resident.

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for specified residents included interdisciplinary assessment related to health conditions including pain.
Progress notes indicate a specified resident was experiencing pain. No pain assessment was completed with these complaints of pain, change in ambulation and noted redness at the site. The resident was started on medication to relieve the discomfort.

A specified resident had documented pain for which she received analgesic. There is no pain assessment within the medical record, no documentation related to the location of the pain or other interventions used to manage pain.
The physician's order indicates the resident was to receive medication orally twice daily.
No pain assessment has been completed for the resident.

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. A specified resident has an area of altered skin integrity for which a treatment cream is prescribed. No weekly skin assessment related to the area of altered skin integrity or effect of the prescribed treatment could be found within the progress notes. Registered staff interviewed identified that weekly head to toe assessments are documented but these assessments only identify the location of the altered skin integrity and do not assess the effectiveness of treatment provided.
2. A specified resident is identified to be at risk of altered skin integrity, was absent from the home on a leave of absence (LOA) on multiple occassions. No skin assessment was completed on return from LOAs. Interview with the DOC confirms that skin assessments are required on return from LOA greater than 24 hours. Policy indicates Head to Toe skin assessments are required on return form LOA greater than 24 hours. No documentation of a skin assessment could be found in the progress notes or the binder containing weekly head to toe assessments.
3. A specified resident has ongoing altered skin integrity. Assessments are not consistently completed weekly related to the status of the altered skin integrity. Notes made related to skin integrity are often incomplete. New areas of skin breakdown are not assessed or reassessed weekly or with healing.
e.g. 2011 Day Registered Nurse reported new open areas. No follow-up documentation was completed, no assessment of the wound areas is documented.
2011 - altered skin integrity identified, bleeding and band aid applied. No follow-up documentation to indicate that the area of altered skin integrity is healed or still present.
4. A specified resident has alteration in skin integrity and receives treatment daily. The DOC confirmed that weekly assessments are to be documented in the progress notes. A review of the progress notes was unable to establish skin assessments completed weekly. When registered staff were asked they indicated the completion of Head to Toe assessments done weekly, however these assessments do not include the status of the altered skin integrity, or effect of treatments provided. The policy related to Skin and Wound care indicates that registered staff will complete weekly assessments of all wounds.

5. A specified resident was admitted with altered skin integrity. This area was healed in 2011. Subsequently the resident was noted to have recurring altered skin integrity and an assessment was completed. No further assessments were completed for a two month period in 2011. No weekly wound assessments have been completed in September 2011. Documentation in the progress notes related to the wounds relate to dressing changes and do not include assessment of the wound areas. The plan of care indicates weekly assessments are to be conducted on the Weekly Wound Assessment sheet. The DOC indicates that since moving to electronic medication administration records, wound assessments are to be completed on the progress notes. The policy related to wounds indicates that wound assessment documentation will include: is the dressing intact, location of wound, size, tracking, undermining, drainage, odour, necrotic tissue, and infection. Progress notes between for the two month period in 2011 do not include this information.

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 ensuring that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; that skin assessments be conducted on residents at risk of altered skin integrity upon return from an absence greater than 24 hours, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that residents receiving drugs were monitored and that their response to the drug and the effectiveness of the drug were documented.
A specified resident has pain and is prescribed analgesic for pain relief. Analgesic medication is given upon the resident's request, however the effectiveness of medication given is not documented consistently since electronic medication administration records were introduced in the home (July 2011). Interview with registered staff and the Director of Care (DOC) confirm that assessment of analgesic effect would be documented in the progress notes. Review of the progress notes confirms that the resident frequently receives analgesic for discomfort. Evaluation of the effect of analgesic given is not documented.
Progress notes indicate that a specified resident was experiencing pain. The resident was started on medication to relieve the discomfort. No evaluation of the effect of this medication was conducted.

WN #5: 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary.
During the course of this inspection the following was noted:
* September 19, 2011 - Floors in the corridor are soiled with spills, appear generally unclean and are heavily scuffed.
* September 19 and 20, 2011 - Glass on the steam table in the Activity Room is heavily soiled with spills of food, water spots and generally appears unclean.
* September 19, 2011 - The Steam table located in the Activity Room is not clean, there are hard-water deposits around the bins and spilled foods on the edges of the stainless containers.
* September 19, 2011 - Wooden chair legs in the Activity Room are heavily soiled.
* September 20, 2011 - The floor in the activity room at the end of hall is visibly soiled. Soiled tissue left on the floor since September 19, 2011 remains on the floor.
* September 20, 2011 - sticky substance running down heat register located across from room 156.

WN #6: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have instituted 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 is complied with.

The policy related to wounds indicates that wound assessment documentation will include: is the dressing intact, location of wound, size, tracking, undermining, drainage, odour, necrotic tissue, and infection. A specified resident in 2011 with altered skin integrity. This area was healed in 2011 but subsequently the resident was noted to have altered skin integrity and an assessment was completed. No further assessments were completed for a two month period in 2011. No weekly wound assessments have been completed in September 2011. Documentation in the progress notes related to dressing changes only and do not include a physical description/assessment of the wound areas. The plan of care indicates weekly assessments are to be conducted on the Weekly Wound Assessment sheet. The DOC indicates that since moving to electronic medication administration records, wound assessments are to be completed on the progress notes.

Skin and Wound policy indicates skin assessments are required on return from an LOA greater than 24 hours. A specified resident is identified to be at risk of altered skin integrity, was absent from the home on a leave of absence (LOA) on multiple occassions in 2011. No skin assessment was completed on return from these LOAs. Interview with DOC confirms that skin assessments are required on return from LOA greater than 24 hours. No documentation of a skin assessment could be found in the progress notes or the binder containing weekly head to toe assessments.

Issued on this 29th day of November, 2011

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