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
Mar 8, 2013	2013_170203_0009	L-000111-13	Resident Quality Inspection

Licensee/Titulaire de permis

LUTHERAN HOMES KITCHENER-WATERLOO
2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7

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

TRINITY VILLAGE CARE CENTRE
2727 KINGSWAY DRIVE, KITCHENER, ON, N2C-1A7

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

CARMEN PRIESTER (203), JUNE OSBORN (105), SANDRA FYSH (190)

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): February 19, 20, 21, 22, 26, 27, 28, 2013

L-000124-13 (complaint) was completed in conjunction with this Resident Quality Inspection Inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Chief Operating Officer, the Director of Care, the Nurse Manager, the Program Services Coordinator. 2 RAI Coordinators, the Resident Accounts Manager, the Physiotherapist, the Registered Dietitian, the Nutrition Mnnager, the Program Services Manager, the Payroll Officer, the Program Manager, the Quality Coordinator, the Administrative Assistant, 7 Registered Practical Nurses, 15 Personal Support Workers, 4 Dietary Aides, 30 Residents and 3 Family Members.

During the course of the inspection, the inspector(s) reviewed clinical records, toured the home, observed dining room service, observed medication administration, observed resident care, reviewed staff education documents, and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Admission Process

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Hospitalization and Death

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Recreation and Social Activities

Resident Charges

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The plan of care did not set out clear directions to staff who were providing direct care to a specified resident. There were no clear directions for direct caregivers about observation of the specified area, interventions to prevent further injury or specific directions regarding daily care.
This was confirmed by the Registered Practical Nurse on the unit. [s. 6. (1) (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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide care to the resident, to be implemented voluntarily.

WN #2: 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 :

Policy from Nursing Manual regarding Skin and Wound Assessments - C-15 states: that skin assessments are to be completed on admission, quarterly, as health status changes and upon a leave of over 24 hours or re-admission from hospital. Wound assessments are completed by nursing staff, Skin and Wound Team or Wound Care Specialist. If a treatment has been prescribed for a wound, an assessment is completed on the assessment form in PointClickCare weekly.
A specified resident had not had a wound assessment completed in PointClickCare quarterly as per policy.
This was confirmed by the RAI Coordinator and the Nursing Manager. [s. 8. (1)]

The home's policy - Nursing Safeguards M-31 regarding restraint use states: "every shift the reassessment to determine if the restraint is to be re-applied, will be initialed by nursing staff on E-mar, indicating need to continue the restraint.
Two identified residents' condition, and effectiveness of the restraints being used, had not been documented as reviewed at least every eight hours.
This was confirmed by the Registered Nursing staff. [s. 8. (1)]

Policy A-4 in the Continuous Quality Improvement manual states that each month the Administrator and each Manager meet to discuss Continuous Quality Improvement results and indicator analysis.
There is no documented evidence to support that this meeting occurs monthly.
The Administrator confirmed that the meeting with the Director of Care has not taken place in the last three months.
The Administrator also confirmed that the meetings were informal and there were no documented minutes. [s. 8. (1)]

The Continuous Quality Improvement manual states that the approach to analysis of Quality Indicators and evaluation of Quality Improvement activities will be interdisciplinary.
The Administrator confirmed that analysis of Quality Indicators and evaluation of Quality Improvement activities was not interdisciplinary. [s. 8. (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 there the policies, plans, protocols, procedures, strategies and systems are complied with, specifically, the Skin and Wound Policies, Restraint Policies and the Quality Management Policies., to be implemented voluntarily.

WN #3: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

During dining observation, staff in the dining room were not aware that a new resident had been admitted. A dietary aide plated a meal for the resident without consulting any admission information. [s. 73. (1) 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's dining and snack service has a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

The home was unable to provide evidence of documentation to support a record of the improvements made to the quality of accommodation, care, services, programs and goods provided to residents.

There were no minutes of meetings, documentation of evaluations or improvement plans.

There was no formal documentation to support the occurrence of regular meetings to review indicators or audit results.

There was no documentation to support communication of improvements to Family Council, Resident Council or staff.

This was confirmed by the Administrator and the Quality Coordinator. [s. 228. 4. i.]

Evaluations that were partially completed for falls and continence but did not contain names of persons participating in the evaluations, nor were there dates that improvements were implemented.

This was confirmed by the Quality Coordinator and the Administrator. [s. 228. 4. 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 improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents are documented with the names of the persons who participated in the evaluations and the dates the improvements were implemented. Further, the licensee must communicate the improvements to the Resident's Council, the Family Council and the staff of the home on a ongoing basis, 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. (2) The licensee shall ensure,
(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).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).

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 :

The licensee did not ensure that a written record is kept related to the evaluation of the infection control program that includes the date, names of persons who participated, a summary of the changes made and the date those changes were implemented.
This was confirmed by the Administrator. [s. 229. (2) (e)]

The Licensee did not ensure that the Infection Prevention and Control Coordinator had experience and education in infection control practices.
This lack of education and experience was confirmed by the Infection Prevention and Control Coordinator and further confirmed by the Administrator. [s. 229. (3) (c)]

The licensee does not ensure that all staff participate in the implementation of the Infection Control Program as evidenced by:
During a dining observation, staff were observed wearing their hairnets covering only the back portion of their hair, when they were entering and exiting the servery to serve plated food to residents.
There was a sign posted at the entry to the servery stating that hairnets are to be worn by staff when entering the servery.
Staff confirmed that it was an expectation that hairnets be worn to cover their hair when entering the servery/plating area. [s. 229. (4)]

The licensee does not ensure that all staff participate in the implementation of the Infection Control Program as evidenced by:
In 13/30 rooms observed, there were unlabeled combs, brushes and toothbrushes, some of which were also noted to be dirty.
An identified bathroom had two bars of soap observed in the same unlabeled container, another shared bathroom had unlabeled denture cups and an unlabeled bedpan was observed in another bathroom.
[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 that the infection control program is in compliance with the regulations specifically addressing annual evaluation of the program, qualifications and experience of the coordinator of the program and staff participation in the program, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee did not ensure that every resident had the right to know who was responsible for and providing their care.
During a meal observation there were 4/6 staff that were not wearing name tags.
It was confirmed by the Nursing Manager that the expectation is that staff wear their name tags at all times while on duty. [s. 3. (1) 7.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

The licensee did not ensure that programs required under section 8 to 16 of the Act and each of the required interdisciplinary programs required under section 48 of the Regulations were evaluated and updated at least annually.
There was no documented evidence to support that formal evaluations of required programs had been completed annually.
This was confirmed by the Administrator and the Quality Coordinator. [s. 30. (1) 3.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

There is no evidence to support that the staffing plan had been evaluated annually. This was confirmed by the Administrator [s. 31. (3)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

The licensee did not ensure that, alternatives to restraining a resident had been considered and tried where appropriate.
A quarterly restraint assessment was completed in PointClickCare for an identified resident requiring a restraint. The assessment did not address interventions that had been considered as alternatives to the retraining device. [s. 31. (2) 2.]

WN #10: 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 :

A clinically appropriate assessment instrument specifically designed for skin and wound assessment had not been used to assess the wounds for specified residents. The Registered Nurse confirmed that no wound assessments had been completed in PointClickCare for these residents.
Progress notes for the residents did not contain appropriate information about the wound. 50. (2) (b) (i)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

Some resident rooms and halls were observed to have damage that had either been repaired and not painted, or not repaired at all.
Environmental Supervisor confirmed that there was no routine preventative maintenance program that addressed resident room/wall repairs. [s. 90. (1) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The licensee did not ensure that all hazardous substance were kept inaccessible to residents at all times.
During the initial tour of the home, a housekeeping cart with chemicals on the top was present in the hallway. There were no staff visibly present in the hallway. [s. 91.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

An evaluation of the effectiveness of the restraint policy to identify changes and/or improvements of the policy is not completed.
This was confirmed by the Nursing Manager. [s. 113. (b)]

WN #14: 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 :

The licensee did not ensure that drugs were stored in an area or medication cart that is used exclusively for drugs and drug related supplies.
Prescription treatments were observed in resident bathrooms.
A Registered staff confirmed that the expectation and the policy are that all prescription creams and treatments are stored in the locked clean utility room in the treatment cart. [s. 129. (1) (a)]

Issued on this 22nd day of March, 2013

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