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
Aug 11, 2014	2014_217137_0019	L-000682-14	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

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

TWIN LAKES TERRACE LONG TERM CARE COMMUNITY
1310 MURPHY ROAD, SARNIA, ON, N7S-6K5

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

MARIAN MACDONALD (137), DEIRDRE BOYLE (504), DONNA TIERNEY (569)

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-August 1 and August 5-7, 2014

Complaint Inspection 001907-14 was completed in conjunction with the RQI.

During the course of the inspection, the inspector(s) spoke with Administrator, Manager - Resident Care, Manager - Life Enrichment, Manager - Food Services, Manager - Environmental Services, Division Manager, Registered Dietitian, Office Coordinator/Scheduler, one (1) Registered Nurse, six (6) Registered Practical Nurses, three (3) Environmental Service Workers, two (2) Food Service Workers, three (3) Life Enrichment Workers, eleven (11) Personal Support Workers, one (1) Physiotherapist, forty plus (40+) Residents and seven (7) Family Members.

During the course of the inspection, the inspector(s) conducted a tour of all resident home areas and common areas, medication room, medication storage areas, kitchen, observed resident care provision, resident-staff interactions, dining service, recreational activities, medication administration, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
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:

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 has failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan as evidenced by:

A review of the plan of care revealed an identified resident had an underlying medical condition and was demonstrating possible signs and symptoms of the condition. The resident was to be assessed for signs and symptoms of the condition, report any signs and symptoms to the Medical Director and a laboratory test was to be completed yearly.

There is no documented evidence the signs and symptoms of the condition were assessed, documented, reported to the Medical Director and no yearly laboratory test was completed.

The Manager - Resident Care confirmed the signs and symptoms were not assessed, documented, reported to the Medical Director, the laboratory test was not completed yearly and the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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 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. 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 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 as evidenced by:

The home conducted a Facility Entrapment Bed Inspection in October 2011.
There is no documented evidence that residents have been assessed to minimize bed entrapment risk.

The Administrator and Manager - Resident Care, both confirmed that residents have not been assessed to minimize bed entrapment risk and the expectation is each resident be assessed to minimize bed entrapment risk. [s. 15. (1) (a)]

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

Observations, throughout the RQI, revealed:

(1) The mattresses slid on the bed frames and were not secured into the corner guards, posing a potential bed entrapment risk, in 8 identified resident rooms.(8/40 = 20%)
(2) During a tour with Inspector # 137, the Administrator confirmed the mattresses slid on the bed frames and were not secured into the corner guards, posing a potential bed entrapment risk.
(3) In one identified resident room, a six (6) inch gap was observed between the mattress and head board and in another identified resident room, a five and a half (5.5) inch gap was observed between the mattress and head board, posing a potential bed entrapment risk.
(4) The Administrator and Manager - Resident Care, confirmed the identified gaps posed a potential bed entrapment risk, and the expectation is measures be implemented to mitigate bed entrapment risk to residents. [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 #3: 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 :

1. The Licensee failed to ensure that the plan, policy, protocol, procedure, strategy or system instituted is complied with as evidenced by:

A review of the home's policy entitled Personal Assistance Services Devices (PASD's) Policy Number RCM 10-09 issued February 11, 2014 indicated:
PASD measures will be assessed, considered and evaluated for appropriateness and effectiveness by completing the "Alternatives to Restraints/PASD's Assessment Form"; consent will be obtained from the Substitute Decision Maker (SDM) or Resident using the "Restraint/PASD Consent Form; the frequency that the resident will use the PASD will be documented.

A review of the clinical record, for an identified resident, revealed there was no documented evidence of an "Alternatives to Restraints/PASD's Assessment Form", there was no Resident/ SDM signed consent on the "Restraint Assessment/PASD/Physician Order Sheet" and that the guidelines and frequency for restraint use was not completed on the order sheet.

The Manager - Resident Care confirmed that the documentation was incomplete and the expectation is that assessments for PASD's are to be completed and available on the clinical chart, as well as consent obtained and guidelines/frequency of use are outlined. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care for an identified resident was based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

A review of the care plan revealed staff were to "Observe, document and refer prn, s/sx of oral/dental problems (pain, ulcers in mouth, lesions, lips cracked or bleeding, teeth missing, loose, broken, decayed, tongue coated, inflamed, smooth)."

A review of the resident's health record revealed no oral assessment had been completed within the past year and this was confirmed by a Registered Staff Member. [s. 26. (3) 12.]

WN #5: 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 :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that complies with the manufacturer's instructions for the storage of the drugs.

During observation of the drug storage area in the Oakwood medication room on July 30, 2014, the following medications were noted to be expired:

Two opened bottles of Cascara: Expired March, 2014.
One opened package of Dulcolax Suppositories: Expired April 31, 2014.
Two bottles of Refresh Liquigel: Expired June, 2014.

The Manager - Resident Care confirmed the medications were expired and the expectation is the medications should have been disposed of according to the manufacturer's directions. [s. 129. (1) (a) (iv)]

Issued on this 11th day of August, 2014

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