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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 3, 2016	2016_380593_0027	013486-16	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

HEARTWOOD
201-11TH STREET EAST CORNWALL ON K6H 2Y6

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

GILLIAN CHAMBERLIN (593), LISA KLUKE (547), MICHELLE JONES (655)

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): September 26 - 30, October 3 - 4, 2016.

In addition, 2 intakes were inspected during the RQI. One reported critical incident log #027377-16 related to falls and one complaint log #026903-16 related to resident care.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Activation Staff, Housekeeping Staff, Personal Support Workers (PSW), residents and family members.

The Inspectors observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, observed a medication administration pass, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

6 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and that those doors must be kept closed and locked when they were not being supervised by staff.

On September 26, 2016, during a tour of the home, Inspector #547 observed the following doors in residential areas of the home:

1.The second floor computer room near the north wing elevator was not locked or supervised by any staff member. It was noted that there was no resident-staff communication system (callbell) in this area and the door knob had a locking mechanism. An RPN indicated to Inspector #547 that this was a computer room for nursing staff to use but that it was supposed to be locked when not in use as it was not for residents to access.

2.The utility room on the first floor north hallway was not locked or supervised by any staff member. The sign on the door read "Please keep this door locked at all times thank you". Inside this utility room, a call bell cord was located with a red plastic cord, however this did not engage a call to the home's communication system. The linen room next to the utility room was also noted to be unlocked and was not supervised by staff and had no accessible call bell.

3.The utility room on the first floor south wing near the dining room was unlocked and not supervised by any staff member. The doorknob was locked however the door could be pushed open by Inspector #547. Inside this room were dirty utility carts, a large sink, a full bottle of vinegar and empty cleaning bottles. It was noted that there was no call bell in this area. Inspector #547 was leaving the utility room when PSW #116 entered the room,

surprised to see the Inspector as the door to this room was supposed to be kept closed and locked when unattended by staff.

4.The door to the basement boiler room was found to be unlocked and was not supervised by any staff members. The door knob to this room was locked however the door was able to be pushed open by the Inspector. A staff member from the basement MDS Co-ordinator's office arrived and indicated that this room was supposed to be kept locked and also noted that the boiler room door was not closed properly.

5.The basement food storage room was observed unlocked by Inspector #547 and was not supervised by any staff member. Inspector #547 entered this room which held dry food for the main kitchen and observed that there was no call bell system in place. The door had a locking mechanism in place however was not locked.

The basement is accessible to all residents and residents were observed in the basement during the inspection.

The Administrator indicated to Inspector #547 that the above rooms identified should have been closed and locked when unsupervised, as they were non-residential areas. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are kept locked at all times and that all staff are aware of all non-residential areas and the doors that are required to be kept locked and inaccessible to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a weight change of five per cent of body weight, or more over one month, and a weight change of 7.5 per cent of body weight, or more over three months, were assessed using an interdisciplinary approach, and that actions and outcomes were evaluated.

Monthly weights were reviewed for resident #009 and it was documented that a 24% weight loss had occurred over a one month period.

A review of resident #011's health care records found that resident #011 was a high nutritional risk and there was no documented assessment related to the 24% weight loss occurring over a period of one month.

Monthly weights were reviewed for resident #016 and it was documented that a 10% weight loss had occurred over a one month period.

A review of resident #016's health care record found that resident #016 was a high nutritional risk and there was no documented assessment related to the 10% weight loss occurring over a period of one month.

Monthly weights were reviewed for resident #009 and it was documented that a 7.5% weight loss had occurred over a three month period.

A review of resident #009's health care record found that resident #009 was a high

nutritional risk and there was no documented assessment related to the 7.5% weight loss occurring over a three month period.

During an interview with Inspector #593, on September 30, 2016, RPN #112 reported that all weights had to be completed by the 7th of each month and if a significant weight loss occurred, they were triggered through to the Dietary Manager. The Registered Dietitian (RD) would review any residents for weight loss however nursing may start some interventions before the RD was able to assess the resident. They also have the ability to complete an electronic referral to the RD for weight loss as well as other nutrition or diet related issues.

During an interview with Inspector #593, on September 30, 2016, the Dietary Manager reported that they have made a recent policy change regarding reviewing of resident weights and significant weight losses. Prior to this change, it was the responsibility of the registered nursing staff to review monthly weights and then refer any significant weight losses to the RD. The Dietary Manager further indicated that this process had not been working so the process was changed so that the RD reviews the monthly weights and creates their own referrals.

A review of health care records for resident's #009, #011 and #016 found no referrals to the RD for significant weight loss.

During an interview with Inspector #593, October 3, 2016, the RD confirmed that the former process for reviewing resident's weights was that registered nursing staff were to refer any significant weight losses to the RD. The RD reported that this process was not working and was unsure if many of the nursing staff even knew how to make a referral. The RD confirmed that they did not receive a referral for resident's #009, #011 or #016 and these residents were not assessed for their significant weight loss.

During an interview with Inspector #593, on October 3, 2016, the DOC reported that the nursing staff don't review the weights as the PSW's measure and record the weights, and then the office manager enters the weights into Point Click Care. The DOC further reported that it was the responsibility of the RD to review the weights and then assess residents who have had a significant weight loss.

A review of the home's policy "Nutritional Assessment and Care" LTC-G-60-ON in effect until August 31, 2016, found that the nurse will review the weights and vitals exception report, assess possible reasons for weight variance and document in the progress notes.

The nurse will then initiate a referral for all significant weight changes to the RD. The RD will document in the progress notes, and any interventions will be care planned for and communicated to the Nutritional Manager for adjustments to the Nutrition Profile in Synergy.

A review of the home's policy "Nutritional Assessment and Hydration" Care7-O10.03, effective date August 31, 2016, found that the RD, Nutrition Manager or Designate reviews the weight report monthly to ensure all significant weight changes have been addressed. The RD re-assesses the resident's nutritional requirements and current intake, as well as other possible reasons for weight variances. In collaboration with the resident and/or family and other members of the interdisciplinary team, the RD initiates interventions to minimize further undesirable weight changes. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 ensuring that all residents who have a significant weight change are assessed using an interdisciplinary approach and that the home's policy related to management of weight changes is communicated to and complied with by all staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #009 and #013's physical devices were applied in accordance with the manufacture's instructions.

On September 27, 28 and 29, 2016, Inspector #547 observed residents #009 and #013 to have a loose fitting safety device applied to their wheelchairs. Both residents were noted to be using the same safety restraint in their wheelchairs and the Inspector was able to place a formed fist between the resident and the edge of the safety device on each of these observations.

Inspector #547 noted during the health record review for both residents that their plans of care identified an intervention, staff to apply the safety devices according to manufacturer's instructions.

On September 29, 2016 PSW #101 indicated to Inspector #547 that residents with safety devices were to be repositioned and the safety devices verified to be properly applied every hour when in use. RPN #102 indicated that the registered nursing staff in the home were responsible each shift to verify that the residents using restraints continued to need the restraint and that it was properly applied. Both PSW #101 and RPN #102 indicated that the safety devices for residents #009 and #013 were applied too loose.

The Assistant Director of Care (ADOC) indicated to Inspector #547 that both safety devices were too loose and that nursing staff were trained to verify the resident's safety devices were applied and tightened as required. The ADOC provided a copy of the safety device installation and user's instructions, which identified that these safety devices must be worn tightly fitted across the resident at all times. A loose safety device can create a risk of strangulation. [s. 110. (1) 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 ensuring that all physical devices used by residents in the home are applied in accordance with the manufacturer's instructions, 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:

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 that care related to urinary continence, set out in the plan of care was provided to resident #025 as specified in the plan.

Resident #025 was admitted to the home in 2015 and is cognitively alert and orientated. Resident #025 had several diagnoses when admitted. Resident #025 had been having difficulty with weakness and required staff assistance with all transfers including toileting. Resident #025 had a medical issue on a specified date in 2016 and since had increased frequency for voiding.

The Director of Care (DOC) indicated to Inspector #547 that the resident was on a trial of a specified toileting routine earlier in 2016 that directed staff to take the resident to the bathroom every two hours. The family for resident #025 wrote in an electronic communication to the DOC, that the resident had been informed by a few PSWs in the home that they could only be toileted every two hours and that the resident was refused to be toileted by a PSW prior to supper as it had not yet been two hours. As a result of this intervention, the resident had been limiting their fluid intake because they were afraid that they would be incontinent between their toileting times and would be embarrassed.

Upon review of resident #025's plan of care, the DOC indicated that they were attempting to establish a toileting routine of every two hours, but she completed a memo to all staff to include that all residents shall be toileted based on request at all times.

On a specified date in 2016, resident #025 called their family member to indicate that another PSW had told them that she would return in two hours to toilet them again and the resident indicated to this PSW that they could not wait that long, and was told by the PSW that was when they could be toileted next.

The Administrator indicated to Inspector #547 on September 30, 2016 that this PSW had not read the information provided to all staff on a specified date in 2016, that was added to the plan of care for resident #025. Resident #025's plan of care indicated that the resident was to be toileted upon request. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that verbal abuse had occurred or may have occurred of a resident by a staff member, immediately reported the suspicion and the information upon which it was based to the Director.

Resident #025 was admitted to the home in 2015 and is cognitively alert and oriented. Resident #025 had several diagnosis when admitted.

On September 30, 2016, a family member indicated during a telephone interview with Inspector #547, that resident #025 was yelled at by a PSW in the dining room recently because they requested an alternate food item. The family member indicated that this was not an acceptable way to treat residents and resident #025 is cognitively alert but treated as if they were cognitively impaired. The family member sent an email to the DOC regarding this incident in the dining room. The family member indicated in this email that the resident was very upset about being yelled at in the dining room and this has caused the resident emotional stress and fear in the home.

Inspector #547 interviewed resident #025 regarding this incident of alleged staff to resident verbal abuse in the dining room. During the interview, resident #025 started to cry and indicated that they did not like to be yelled at and that they were not stupid. Resident #025 indicated that they simply did not like a certain food and wanted it

replaced with something else.

The DOC indicated during an interview with Inspector #547 that she immediately investigated this alleged staff to resident verbal abuse as this behaviour was not acceptable in the home. The DOC further indicated that she had not reported this incident to the Director. [s. 24. (1)]

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that verbal abuse had occurred or may have occurred of a resident by a staff member, immediately reported the suspicion and the information upon which it was based to the Director.

Physical abuse as defined in Ontario Regulation 79/10 "the use of physical force by anyone other than a resident that causes physical injury or pain".

During an interview on September 28, 2016, resident #019 indicated to Inspector #547 that a nurse had rushed them, pulled them by the right hand, and caused an injury. Resident #019 further indicated to Inspector #547 that this incident scared them. At a later date, resident #019 was able to relay the incident to Inspector #655, with no change in details.

Inspector #655 reviewed the medical record of resident #019:

In the care plan, it was indicated that on a specified date in 2016, resident #019 had sustained an injury when they attempted to strike a staff member; but instead hit a side rail.

Inspector #655 reviewed the progress notes for a particular period:

In an entry on a specified date during the night shift by RN #122, it was indicated that resident #019 stated "look what they did to me". In the same entry, it was noted that staff had reported that resident #019 attempted to strike one staff member; and then, with both arms flailing, resident #019 struck the bed rail, resulting in an injury. A progress note entered by RPN #129 during the evening shift on the same day indicated that resident #019 requested a pain medication for pain related to their injury.

During an interview on October 3, 2016, resident #019 indicated to Inspector #655 that the incident which they had previously reported to Inspector #547, occurred a few

months ago.

During a second interview, resident #019 remained consistent with their account of this incident. Resident #019 indicated that they were injured by a staff member during care. Resident #019 denied ever having injured themselves on the bed rail. At the time of the interview, resident #019 could not recall the name of the staff member involved in the incident. Resident #019 did recall reporting it to the nurse who was on duty that night, and that the nurse had assessed their injury and put a bandage on it.

During an interview on October 4, 2016, RN #122 indicated to Inspector #655 that at the time of the incident, resident #019 reported to her that a staff member caused the injury. RN #122 indicated that there was a discrepancy between what resident #019 had reported and what staff had reported. RN #122 indicated that she was not certain what had happened to result in the injury to resident #019 and acknowledged that based on previous interactions, it was possible that one staff member had pulled the resident during care too hard. RN #122 did not identify the staff member in question.

RN #122 indicated that she reported the incident to the in-coming registered staff member, but did not report it further to the DOC/Designate or the Director. RN #122 acknowledged that any abuse or potential abuse, quoting"even the thought of it", must be reported immediately. [s. 24. (1)]

WN #6: 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 :

1. The licensee has failed to ensure that all hazardous substances in the home were kept inaccessible to residents at all times.

On September 29, 2016, Inspector #655 observed there to be two bottles labelled "CaviCide Surface Disinfectant" (CaviCide) sitting on the back of the toilet in a resident bathroom where it was unlocked, unattended, and accessible to residents. The product

bottle was observed to have a symbol indicating that the product was corrosive.

During an interview with Inspector #655 on the same day, Housekeeping Aide #106 indicated that this product was kept in this resident bathroom so that night staff have access to it for cleaning.

During an interview on September 29, 2016, with Inspector #655, Housekeeping Supervisor #111 indicated to Inspector #655 that the CaviCide product was implemented by nursing; and that it was put in place to address a specific infection control concern. At the time of the interview, Housekeeping Supervisor #111 indicated that this product was in eight or nine different resident rooms.

On September 30, 2016, Inspector #655 observed the same product in two additional resident bathrooms. In each bathroom, the product was unlocked and accessible to residents.

During an interview on September 30, 2016, with Inspector #655, RPN #112 indicated that cleaning products were not to be kept in resident rooms or bathrooms. After examining the bottle of CaviCide, RPN #112 indicated that this product was not safe to be kept in resident rooms or bathrooms - especially because there are residents who wander.

During an interview on September 30, 2016, with Inspector #655, the DOC indicated that the CaviCide product was implemented by nursing for infection control purposes, and that it was to be kept in specific resident bathrooms for this reason.

Inspector #655 reviewed the Material Safety Data Sheet (MSDS) for the product named CaviCide. On the MSDS, the product was described as a "hard surface cleaner and disinfectant". According to the MSDS, CaviCide is harmful if absorbed through the skin; and inhalation of concentrated vapors may cause irritation of the eyes, nose and throat, dizziness and drowsiness. It was also stated on the MSDS that prolonged exposure to the ingredient "ethylene glycol monobutyl ether may affect liver, kidneys, blood, lymphatic system or the central nervous system".

During an interview on October 3, 2016, with Inspector #655, Housekeeping Supervisor #111 indicated that based on the MSDS, this product contained hazardous substances and should not be kept unlocked in resident bathrooms. [s. 91.]

Issued on this 3rd day of November, 2016

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

Original report signed by the inspector.