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
Oct 6, 2014	2014_340566_0014	T-042-14	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

HUMBER VALLEY TERRACE
95 Humber College Blvd., Rexdale, ON, M9V-5B5

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

ARIEL JONES (566), JOANNE ZAHUR (589), NATASHA JONES (591), SLAVICA VUCKO (210)

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 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17 and 19, 2014.

The following log and inspection numbers were conducted in conjunction with this inspection: Log #T-656-13, Log #T-437-14, Log #T-178-14, Log #T-266-14, Log #T-962-14, and Log #T-196-14.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), resident assessment instrument minimum data set (RAI-MDS) coordinator, environmental services manager (ESM), dietary manager (DM), food service manager (FSM), registered dietitian (RD), programs manager, physician (MD), nurse practitioner (NP), registered staff members, personal support workers (PSW), dietary aides, laundry aide, housekeeper, education coordinator, Family Council president, Residents' Council president, residents and family members.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed staff to resident interactions and provision of care, observed meal service, medication administration, reviewed relevant home records, relevant policy and procedures, training records, employee records and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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.) 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. (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).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

An interview with resident #042 revealed that the resident refuses showers due to his/her perception that personal clothing is taken by staff and not returned.

A record review of resident #042's written care plan revealed that the resident refuses showers, but does not address the underlying reason for his/her refusals of showers and does not include any interventions or strategies specific to his/her perception that clothing is being taken when he/she is being showered.

Interviews with identified PSWs, registered staff, and the DOC confirmed that the written plan of care does not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Interviews with PSW staff revealed that resident #023 tends to interfere with his/her spouse's care, has anxiety over his/her spouse's care needs, and uses the call bell frequently for staff to check on his/her spouse.

Record review of the resident's current written plan of care as of September 5, 2014, indicated that the resident has reduced psychosocial well being and sad moods, but fails to identify moods or behaviours related to his/her spouse's health status. Further review of the resident's printed care plan kept at the nursing station, from a specified date, indicated that the resident has delirium or acute confusional episodes related to

a history of anxiety disorder and changes in mood due to changes in the health status of his/her spouse.

An interview with the registered staff confirmed that the resident continues to exhibit anxiety around his/her spouse's health status and that this is not outlined in his/her current care plan.

An interview with the RAI-MDS Coordinator stated that care plans are currently in transition to a new system, but confirmed that all previous interventions that are still relevant should have been transferred over to the new electronic care plan and this information had been missed. [s. 6. (1) (c)]

3. An interview with an identified PSW indicated resident #002 communicates only in an identified language, that staff communicate using gestures, and when the resident's daughter visits she translates for the resident, if needed. Interviews with registered nursing staff confirmed that the resident speaks the identified language, may require use of a translator, and that one of the methods that staff use to communicate with the resident is with gestures.

Review of the current written plan of care and an interview with a registered nurse revealed that the care plan kardex (that PSWs have access to on Point of Care) does not contain a section for communication.

An interview with the RAI-MDS Coordinator confirmed that there was a section related to communication in resident #002's previous care plan, and stated further that care plans are currently in transition to a new system. She confirmed that all previous interventions that are still relevant should have been transferred over to the new electronic care plan and this information had been missed. [s. 6. (1) (c)]

4. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care.

Review of the clinical record for resident #003 indicated the resident had a stage 2 pressure ulcer on the coccyx in July 2014, and a stage 3 pressure ulcer in August 2014, in the same location. A review of the flow sheets indicated that resident #003 required repositioning every two hours when up in a wheelchair. During the month of August 2014, it was documented by PSWs that this intervention was not applicable.

An interview with an identified PSW indicated staff would turn and reposition the resident every two hours while the resident was in his/her wheelchair, and they continued to reposition him/her while in bed. However, there were no flow sheets initiated for turning and repositioning of the resident in bed and therefore it was not documented.

Review of the policy for the skin and wound care program indicated that residents who are unable to reposition themselves while in bed, even if they are on a therapeutic surface, will be repositioned by staff at a minimum of every two hours or more frequently as required depending on the resident's condition. [s. 6. (8)]

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 plan of care sets out clear directions to staff and others who provide direct care to the resident, and that staff and others who provide direct care to a resident are kept aware of the contents of a resident's plan of care, to be implemented voluntarily.

WN #2: 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:

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; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(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 has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observations of the second floor west tub room revealed multiple scuff marks on the outside of the entrance door, multiple cracked tiles throughout the tub room, dirty grout on floor tiles, two rusted radiators, two ceiling repair areas above toilet not completely finished, as well as a ceiling area above tub near light fixture not completely repaired.

Observations of the first floor west tub room revealed peeling ceiling paint in top northwest corner of the shower room with peeled paint chips on the floor, ceiling access door in left corner of shower held up in place with duct tape, areas of blistering ceiling paint, and rusty, dented radiators between the bathtub and wall.

Interviews with the ESM and ED confirmed these areas of disrepair in the above mentioned tub rooms. The ED stated further that these two tub rooms have planned renovations with costs approved by the home's corporate office, and an operational plan has been submitted to the MOHLTC for repairs to both identified tub rooms. [s. 15. (2) (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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

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:

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 :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers, has received 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.

Review of the clinical record for resident #003 indicated that the resident came back from hospital on a specified date, and the registered nursing staff documented altered skin integrity in the progress notes related to redness on an identified area of the body, but failed to complete a clinically appropriate wound assessment tool.

An interview with registered nursing staff indicated that when a skin and wound assessment is performed it is documented in the head to toe assessment tool and the initial wound assessment-treatment observation record.

The wound care champion confirmed that the resident's skin was assessed on a second identified date, as a stage 2 wound, and that it was documented in both the head to toe assessment tool and initial wound assessment-treatment observation record. The head to toe assessment tool from an identified third date, indicated the wound had progressed to a stage 2 that was larger in size.

An interview with a member of the registered nursing staff confirmed that the initial skin and wound assessment for the stage 1 pressure ulcer observed on the first

identified date, was not performed using a clinically appropriate instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including pressure ulcers, has been assessed by a registered dietitian (RD) who is a member of the staff of the home, and any changes made to the plan of care related to nutrition and hydration are implemented.

A review of the clinical record indicated that on a first specified date, resident #003 had reddened skin on an identified area of the body. On the second identified date, the skin assessment indicated a stage 2 pressure ulcer of an identified size. On a third date the skin assessment indicated a stage 3 pressure ulcer of an identified size. An interview with the RD indicated that a referral should be sent to the RD for any skin problems, including skin tears and/or pressure ulcers.

Interviews with the RD and registered nursing staff confirmed a referral was not sent to the RD when the skin problems were first noted. The resident was not assessed by the RD until approximately six weeks after the first identified date, regarding the resident's nutritional status and skin problems. [s. 50. (2) (b) (iii)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives the following:
- 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, and
- an assessment by a registered dietitian, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

A review of resident #023's weights failed to reveal evidence of his/her weight being recorded during the month of August, 2014. Further record review revealed that the resident was hospitalized for approximately one week during August 2014.

Interviews with non-registered and registered staff confirmed that residents are weighed monthly and upon readmission from hospital. An identified member of the registered nursing staff confirmed that the resident was not weighed in August 2014, upon his/her return from hospital.

Further review of the home's policy entitled Height Measurement and Weight Management (#LTC-G-60, revised June 2014) stated that residents will be weighed and their weights documented by the 7th of each month.

An interview with the RD confirmed that residents' weights are to be recorded monthly and upon readmission from hospital. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's height on admission and annually thereafter.

A review of resident #002 and #003's clinical records and interviews with registered nursing staff indicated the most recent height for resident #002 was taken on May 27, 2011, and for resident #003 on November 20, 2012.

An interview with the registered nursing staff confirmed that the heights of residents are not taken annually. [s. 68. (2) (e) (ii)]

3. Record review for resident #023 revealed that the resident was admitted to the home on June 9, 2011. The resident's identified height was recorded on June 20, 2011, but further record review failed to reveal evidence of the resident's height having been recorded annually thereafter.

Interviews with registered staff and the RD revealed that residents' heights should be measured annually, and that the dietitian refers to the height listed under the weights/vitals section of the electronic documentation in order to calculate Body Mass Index (BMI).

Review of the home's policy entitled Height Measurement and Weight Management (#LTC-G-60, revised June 2014) confirmed that the home must have a process in place to measure residents' heights upon admission and, at a minimum, annually thereafter.

Interviews with the ADOC and DOC confirmed that all residents' heights are not being recorded annually, but that during this inspection the home had taken action to measure and record residents' heights. [s. 68. (2) (e) (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 the nutrition and hydration program includes, a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter, and a height monitoring system to measure and record each resident's height on admission and annually thereafter, to be implemented voluntarily.

WN #5: 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 failed to ensure that residents with the following weight change are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated when there is a change of 5% of body weight, or more, over one month.

Review of the clinical record for resident #003 indicated that on June 2, 2014, the resident's weight was 60.6kg and on July 2, 2014, it was 56.8kg, which was a change of at least 5% of body weight over one month.

Interviews with registered nursing staff and the RD confirmed that a referral was not sent to RD in order to assess this resident. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. A review of resident #042's health record from August 2014, revealed a weight loss of 3.4kg over 30 days, indicating a 5% weight loss over one month. Further record review revealed that there was no RD referral to address resident #042's 5% weight loss.

An interview with the DOC revealed that the home's policy requires an RD referral for any weight loss of 5% over a month, 7.5% over 3 months, and 10% over 6 months. The expectation is that the registered staff completes a progress note entry regarding the rationale for the RD referral. The DOC confirmed that a dietary referral was not completed and forwarded to the RD for resident #042. [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 to ensure that actions are taken and outcomes evaluated when residents experience significant weight changes as specified in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interviews with the President of Family Council and the ED confirmed that the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

An interview with the Residents' Council staff support person and the ED confirmed that the licensee does not seek the advice of the council in developing and carrying out the survey. [s. 85. (3)]

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 licensee seeks the advice of both the Family Council and Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #7: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the infection prevention and control program.

During observation of the noon medication administration pass, the registered staff did not sanitize his/her hands between two residents and did not wear disposable gloves when instilling eye drops to resident #047.

An interview with the registered staff confirmed that he/she was aware that he/she should sanitize his/her hands in between residents when administering medications. [s. 229. (4)]

2. - Observation performed on September 3, 2014, at 11:30a.m. in room 315's shared washroom indicated the presence of a non-labeled urine collection basin on the floor.
- Observation performed on September 3, 2014, at 11:00a.m. in room 313 indicated the presence of a non-labeled toothbrush and toothpaste on the shared sink counter.
- Observation performed on September 3, 2014, at 01:00p.m. indicated the presence of a non-labeled toothbrush and toothpaste on the shared sink counter.
- Observation performed on September 9, 2014, at 11:40a.m. in the hallway, in front of room 208, identified an environmental staff wearing a surgical mask on his/her neck and later putting the mask in the pocket of his/her pants.
An interview with the identified staff confirmed the personal protective equipment (PPE) should be worn only in the resident's room, and not in the hallway.

An interview with the ADOC confirmed that as per the infection prevention and control (IPAC) practices, all personal care items in shared rooms and washrooms should be labeled, and that the PPE should be worn and disposed of in the resident's room. [s. 229. (4)]

3. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of resident clinical records and an interview with the ADOC, one of the leaders of the IPAC program, indicated that the home does not offer immunization against tetanus and diphtheria (TD) to residents; however the home has had the vaccine available in the vaccine fridge since June 2014, and it was discussed at the multidisciplinary resident care committee meeting on September 4, 2014, that the home would start with obtaining consent and giving the TD vaccine to residents. [s. 229. (10) 3.]

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 staff participate in the infection prevention and control program, specifically as it relates to hand hygiene, storage and labeling of residents' personal care equipment, and proper use of personal protective equipment, and to ensure the tetanus and diptheria vaccine is administered to residents in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #8: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that full recognizes his/her individuality and respects his/her dignity, is fully respected and promoted.

During a resident interview on September 3, 2014, resident #021 reported that his/her privacy is not respected as PSWs walk into his/her room at any time to wash their hands.

On September 9, 2014, an identified PSW was observed to walk into two identified resident rooms on the same unit where resident #021 resides, to wash his/her hands in the resident's sinks without knocking or asking permission from the residents first.

Interviews with PSW staff revealed that there is a common sink on the floor that PSW staff are expected to use to clean their hands when soiled, but that a PSW may use the sink in a resident's room after care has been provided. An identified PSW confirmed the observation that he/she had used two resident room sinks that morning to wash his/her hands without knocking or asking first, and stated that it may make a resident feel bad to have their private area used without permission.

An interview with an identified member of the registered staff confirmed that it is not acceptable for staff to treat sinks in resident rooms as common sinks for their use, but that with permission they may use a resident's sink after providing care. This identified staff member stated further that it would be an invasion of a resident's privacy for staff to disturb them unnecessarily to wash their hands using the resident's personal sink.

An interview with the ED confirmed that staff members using a resident's sink without asking their permission is a violation of a resident's right to be treated with courtesy and to have their privacy respected. [s. 3. (1) 1.]

WN #9: 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 license failed to ensure that the policy for prevention and management of specific infectious disease, antibiotic resistant organisms (ARO) is complied with.

Review of the policy Prevention and Management of Specific Infectious Diseases, AROs (#IPC-D-10, updated May 2014), in the section "National operating procedure" indicates "Ongoing screening/surveillance cultures will be collected based on local laboratory instructions and regional/provincial requirements and guidelines."

The section for management/treatment of AROs indicates: "additional precautions will be implemented by the nurse in addition to routine practices, if required, and as per regional/provincial guidelines." Point seven of the same section states that specific interventions related to care and treatment of a resident with an ARO colonization or infection will be documented on the care plan. Point eight indicates that additional precautions will be discontinued based on clinical symptoms, culture results and regional/provincial guidelines in consultation with the infection control coordinator/designate.

Review of the clinical record for resident #004 indicated that the resident was positive for Methicillin-Resistant Staphylococcus Aureus (MRSA) in axilla and nares on a specified date. An interview with a member of the registered nursing staff indicated the resident was on contact precautions until an identified later date, when laboratory results were received that the resident was negative for MRSA in axilla and nares and the contact precautions were discontinued.

Review of the Provincial Infection Disease Advisory Committee (PIDAC) guidelines states that if an individual has undergone decolonization therapy for MRSA, this may affect the duration of contact precautions. In the event that three sets of specimens for MRSA have been taken at least one week apart and have been found to be negative,

the infection control practitioner (or their delegate) may discontinue contact precautions (57, 58). When decolonization is not attempted, the majority of people remain colonized with MRSA for weeks to months (140) and should remain on contact precautions. In long-term care: if the resident has been colonized for more than one month, follow-up screening should be done no more frequently than every three months, and if contact precautions have been discontinued, monthly screening for six months is recommended following eradication of MRSA since re-colonization can occur.

The home did comply with the policy and the regional/provincial guidelines as it pertained to the discontinuation of additional precautions. [s. 8. (1) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours.

The written plan of care for resident #023 did not identify written strategies or interventions related to the resident's responsive behaviours and rudeness toward staff, or the management of these behaviours.

Record review and interviews with both an identified PSW and registered staff revealed that resident #023 has identified responsive behaviours. An interview with an identified member of the registered staff confirmed that these behaviours are not new and that staff have just come to expect them from the resident. The registered staff confirmed that the resident's written plan of care does not include a focus related to rudeness toward staff or responsive behaviours.

An interview with the resident on September 11, 2014, confirmed that he/she has been rude to staff and provided specific examples of the behaviour.

An interview with the DOC confirmed that a resident being rude to staff or making threatening statements is considered a responsive behaviour and should be outlined in the resident's written plan of care. [s. 53. (1) 1.]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations, the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

The ED confirmed that he does respond using the "Residents' Council Concerns Log", but that the form is not dated and therefore it is not clear whether the licensee's response has been provided to the Residents' Council within 10 days. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning of the home, specifically the first floor common area carpet.

A review of the contracted service's policy titled Staff Daily Cleaning Routines Heavy Duty Cleaner #1 (#HKG B-15-30, approved December 2008), outlines a Monday to Friday daily cleaning schedule. On Fridays, the heavy duty cleaner #1 is to steam clean the carpet in the central area located on the first floor.

An interview with the ESM confirmed that on Friday, September 5, 2014, the full time heavy duty cleaner was on vacation, the part time heavy duty cleaner was off as well, and that the shift was filled by an identified housekeeper. The steam cleaner was reportedly too heavy for the relief employee to use, and as a result, the carpeting in the central area on first floor was not steam cleaned as per the schedule.

An interview with the ED confirmed that arrangements to steam clean the central area carpet on an alternate day were not addressed. [s. 87. (2) (a)]

WN #13: 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 has failed to ensure that where drugs are stored in an area or medication cart, that it is used exclusively for drugs and drug-related supplies.

An observation completed on September 10, 2014, of the first floor medication cart revealed the following items stored in the locked narcotic bin:
- a clear plastic bag containing a silver key,
- a clear plastic bag containing a gold ring with a small rectangular diamond like stone mounted in the centre,
- a clear plastic bag containing a gold ring with three red stones mounted in the centre of the band,
- a clear plastic bag containing a single gold earring of an identified resident,
- an envelope containing a report related to the modified duties of an identified PSW, and an additional copy of the same report outside of the envelope.

An interview with the registered staff revealed that he/she has not received any direction to indicate that the above mentioned items should not be stored in the medication cart's narcotic bin.

The DOC confirmed that non-drug related items and supplies are not to be stored in the narcotic bin location within the medication cart. [s. 129. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that every drug that is received in the home is dated when received, and that the signature of the person acknowledging receipt of the drug on behalf of the home is recorded in the drug record book.

A review of the drug record book on the third floor revealed multiple missing dates indicating when drugs were received in the home during the month of August 2014, as well as missing signatures of staff acknowledging receipt of the drug on behalf of the home.

An interview with a member of the registered staff confirmed that the staff receiving these medications should have signed and dated the drug record book upon receipt of the medications. [s. 133.]

Issued on this 21st day of October, 2014

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

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