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

Division des foyers de soins de longue durée
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
Sep 14, 2016	2016_382596_0013	0011490-15	Follow up

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

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON M4E 2V6

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

THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 24 and 29, 2016.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Associate Director of Care (ADOC), staff educator (SE), physiotherapist (PT), wound care champion (WCC), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW) and residents.

During the course of the inspection, the inspector observed resident care, staff to resident interactions, interviewed resident and staff, reviewed schedules, resident health records, and relevant policies and procedure.

The following Inspection Protocols were used during this inspection:
Pain
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6.	CO #001	2015_369153_0002	596

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. 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is dependent on staff for repositioning had been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

During this follow up inspection, an identified resident was listed on the home's resident list as non-ambulatory with impaired skin integrity.

Record review of the identified resident's progress notes revealed the resident returned from hospital on a specified date in February 2016, after receiving treatment for a medical condition.

Record review of the resident's initial wound assessment, care plan and interview with the wound care champion (WCC) revealed that the impaired skin integrity was discovered on a specified date in February 2016.
Record review of the resident's current MDS assessment for bed mobility (section G) indicated that resident was totally dependent and required two person assistance for bed mobility.

Interview with the physiotherapist confirmed that the resident currently had impaired skin integrity and limited mobility. Physiotherapy plan of care indicated a therapeutic positioning program which directed staff to reposition the resident every two hours when lying in bed for positioning, comfort and for prevention of deterioration with pillows between legs.

On a specified date in August 2016, during an interview with the identified resident, with an identified registered practical nurse (RPN) present, the resident reported that he/she had impaired skin integrity and the nurses were dressing the area, however staff do not assist her to reposition herself in bed. Resident stated that he/she had not been repositioned while in bed or wheelchair on the day shift, only transferred from bed to chair.

Interview with personal support worker (PSW) #103 who provided care to the resident on the day shift on the above mentioned specified date in August 2016, revealed that he/she had repositioned the resident during the shift every two hours while he/she was in bed, together with PSW #110.

Interview with PSW #110 reported that she assisted PSW #103 with transferring the resident from bed to chair, however did not assist with any repositioning of the resident

on the day shift.

Interview with the Associate Director of Care (ADOC) revealed that the home's expectation is that staff reposition residents with impaired skin integrity, and who require assistance with repositioning, every two hours or more frequently as directed by residents' plan of care. [s. 50. (2) (d)]

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 who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

During this follow up inspection, an identified resident was listed on the home's resident list as non-ambulatory with impaired skin integrity.

Record review of the identified resident's progress notes revealed resident returned from hospital on a specified date in February 2016, after receiving treatment for a medical condition.

Record review of the resident's initial wound assessment, care plan and interview with the wound care champion revealed that the alteration in skin integrity was discovered on a specified date in February 2016.

Record review of the resident's current MDS assessment for bed mobility (section G) indicated that resident was totally dependent and required two person assistance with bed mobility.

Interview with the physiotherapist confirmed that the resident currently had impaired skin integrity and limited mobility. Plan of care indicated a therapeutic positioning program which directed staff to reposition resident every two hours when lying in bed for positioning, comfort and for prevention of deterioration with pillows between legs.

Record review of the resident's repositioning documentation in Point of Care (POC) revealed no electronic signatures for repositioning the resident every two hours on a specified date in August 2016, four times throughout the shift.

Interview with PSW #111 revealed that she repositioned the resident on the above mentioned specified date in August 2016, during the day shift and documented in the POC. PSW #111 was not sure why there were no visible electronic signatures.

Interview with the ADOC confirmed that there were no electronic signatures for repositioning the identified resident on the above mentioned specified date in August 2016, on the day shift by PSW #111, and staff are expected to document all care provided to residents. [s. 30. (2)]

Issued on this 15th day of September, 2016

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

Original report signed by the inspector.