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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 20, 2015	2015_389601_0007	O-001096-14, O-001310-14	Complaint

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY PICTON ON K0K 2T0

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

KARYN WOOD (601), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 24-26, 2015

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Associate Director of Care (ADOC), Food Service Manager (FSM), Resident Service Coordinator (RSM), Registered Nurses(RN), Personal Support Workers (PSW), Residents, Family members of residents.

The inspectors also reviewed the clinical records, policy related to skin and wound, observed resident care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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)**

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. (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. (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 comply with LTCH 2007, s.6.(1) (c) where by a resident's plan of care related to nutritional risk does not set out clear directions to staff and others who provide direct care to Resident #1.

A review of Resident #1's clinical records indicated Resident #1 has been assessed as high nutritional risk.

A review of Resident #1 current plan of care indicates Resident #1 exhibits responsive behaviours as evidenced by resistive to care and meals. Interventions included if strategies are not working to leave Resident and re-approach in 5 to 10 minutes.

Resident #1 was observed on an identified date being encouraged to go to the dining room for a meal by PSW #102 and RN #105. Resident #1 declined both times. PSW #102 and RN #105 did not offer Resident #1 tray service.

During an interview PSW #102 indicated Resident #1 refused to come to the dining room. Resident #1 will usually refuse to go to the dining room, and a meal service tray is not offered because Resident #1 has snacks in the room.

Resident #1 was interviewed on an identified date with PSW #102 present and the resident indicated that a sandwich would be eaten, if provided. PSW #102 did not provide Resident #1 with a sandwich, after it was indicated that a sandwich would be eaten.

During an interview the Food Service Manager, Assistant Director of Care, and the

Director of Care it was indicated the home's expectation that a tray be provided to Resident #1 if the resident was refusing to go to the dining room for a meal.

Resident #1's plan of care identified responsive behaviours and that Resident #1 can be resistive to meals, strategies in place were to re-approach in 5 to 10 minutes. PSW #102 who provides direct care to Resident #1 did not have clear direction to provide Resident #1 with a tray; if the resident was refusing to go to the dining room for a meal. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, s.6.(1) (c) where by a resident plan of care related to risk for falls does not set out clear directions to staff and others who provide direct care to the resident.

Plan of care was reviewed and indicated that Resident #1 is at high risk for falls. Resident #1 attempts to ambulate without walker or assistance. Interventions include checking every 15 minutes to ensure safety, document in point of care.

The inspector observed Resident #1 on an identified date walking without assistance several times and was not always using the walker. During this time, Resident #1 was not checked every 15 minutes by staff and a review of point of care documentation showed no record of every 15 minute checks.

During an interview PSW #102 and the Assistant Director of Care indicated that 15 minutes checks are no longer required for Resident #1.

Therefore, there was no clear direction regarding the frequency of safety checks related to Resident #1 risk for falls. [s. 6. (1) (c)]

3. The licensee has failed to comply with LTCHA 2007, s.6.(7) where by the care set out in the plan of care was not provided to Resident #1 as specified in the plan related to high risk for falls.

Plan of care was reviewed and indicated that Resident #1 is high risk for falls, attempts to ambulate without walker or assistance. Interventions include leaving call bell within reach and lounge chair has been moved beside bed so Resident #1 is visible to staff from the hallway. Resident #1 was observed sitting in the lounge chair, to the right inside the door, not in view from the hallway. The resident's call bell was across the bed, Resident #1 could not reach it without standing and taking a few steps.

During an interview PSW #102, RN #106, and the Assistant Director of Care confirmed the lounge chair is to be placed next to Resident #1's bed so staff can monitor Resident #1 from the hallway. They also confirmed Resident #1 should have the call bell within reach. [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 that Resident #1 plan of care sets out clear direction to staff and others who provide direct care related to nutritional and falls risk. The care set out in the plan of care for Resident #1 is provided as specified in the plan and that the plan of care is based on resident's assessed needs related to falls risk, 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 :

1. The licensee failed to comply with O.Reg. 79/10, s. 8(1)(b) where by the home did not ensure that the skin and wound care program was complied with.

O.Reg. 79/10, s. 48(1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

On an identified date Resident #1 was found on the floor with an injury. Resident was transferred to the hospital for further assessment and treatment.

The home's policy entitled Skin and Wound Care Program stated the following with regards to number five under the heading Prevention of Skin Breakdown:

All Residents will have a Head -to-Toe Assessment [LTC-E-90-05] (or on PCC) completed under the following criteria: Within 24hrs of admission; within 24hrs of returning from hospital; within 24 hours of returning from a leave of absence greater than 24 hours; whenever there is change in health status that affects skin integrity.

Upon review of Resident #1's health care record there was no evidence of a Head-to-Toe Assessment or other skin related documentation being completed within 24 hrs of returning from hospital; or when there was a change in health status that effected Resident #1 skin integrity.

During an interview the Assistant Director of Care (ADOC) and the Director of Care (DOC) indicated it is the home's expectation that a Head-to Toe Skin Assessment be completed in point click care when impaired skin integrity has been identified. The ADOC and DOC confirmed that a Head-to-Toe Skin for Resident #1 was not completed when Resident #1 returned from the hospital. [s. 8. (1) (a),s. 8. (1) (b)]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.