Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of inspection/Genre d'inspection
Aug 14, 15, 16, 23, Sep 4, 2012	2012_088135_0027	Critical Incident

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

SUMMIT PLACE
850-4TH STREET EAST, OWEN SOUND, ON, N4K-6A3

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

BONNIE MACDONALD (135)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with Acting Director of Care, Assistant Director of Care, Kinesiologist, 2 Registered Practical Nurses, 2 Personal Support Workers, and resident.

During the course of the inspection, the inspector(s) reviewed critical incident report, resident's clinical records, policies and procedures, observed resident, resident care and second lunch service in the home.

Log# L-000916-12

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Safe and Secure Home

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A review of clinical records revealed, resident has had falls in 2012.
The Falls Interventions Risk Management Program policy #LTC-N-75, dated Feb. 2012 was not complied with when the resident fell and the following information was not part of the post fall assessment:

-the logo "falling star" was not used for resident who has been assessed at immediate risk for falls i.e. resident who has had a recent fall in the past 6 months.
-the Resident Fall Documentation form LTC-N-75-10 was not used for resident's prior fall incidents in 2012 as part of the multidisciplinary progress notes.

In interview, the Assistant Director of Care confirmed the expectation that, the Falls Interventions Risk Management Program policy #LTC-N-75, dated Feb. 2012 be complied with when doing a post fall assessment of residents. [O.Reg. 79/10s .8(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 ensuring the Falls Interventions Risk Management Program policy is complied with when doing post falls assessments of residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. During inspection, observed resident-staff communication "Call Bell" system was not easily accessible for resident. In interview with resident, observed call bell was wrapped around lowest rung of the bed rail close to the floor, out of reach of resident resting in bed.

In interview, the Assistant Director of Care confirmed the expectation that resident's "Call Bells" must be easily accessible to residents in their rooms, at all times. [O.Reg.79/10,s.17.(1)(a)]

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 resident's call bells be easily accessible to residents in their rooms, at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following subsections:

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. A review of the clinical record revealed resident is to receive Tylenol as prescribed by the Physician.

In review of the resident's MARS (Medication Administration Record System) with Registered Practical Nurse omissions of Tylenol documentation were observed as per the Physician's order.

In interview, Assistant Director of Care confirmed her expectation that any actions taken with respect to a resident under a program, including medication interventions for pain be documented.[O. Reg. 79/10, s. 30 (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 any actions taken with respect to a resident under a program, including interventions i.e. medication for pain be documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. In review of home's Critical Incident report, the licensee failed to inform the Director no later than one business day after resident was transferred to hospital.

In interview, the Assistant Director of Care confirmed the home had not notified the Director no later than one business day after resident was transferred to hospital with an injury. She stated she was not aware of the requirement to inform the Director no later than one business day after injury resulting in resident being taken to hospital. [O. Reg. 79/10, s. 107 (3) 4.]

WN #5: 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 subsections:

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. A review of the plan of care for resident revealed that resident's bed is to be kept at lowest level in locked position when resident is in bed.

The care specified in resident's plan of care was not provided as the bed was not in the lowest position as observed with Registered Practical Nurse.

In interview, the Assistant Director of Care acknowledged, her expectation the plan of care is provided and the resident's bed is kept at lowest level in locked position when resident is in bed. [LTCHA, 2007, S.O. 2007, c.8, s. 6 (7)]

Issued on this 4th day of September, 2012

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

Bonnie MacDonald