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

Division de la responsabilisation et de la performance du système de santé
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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
May 11, 2015	2015_206115_0011	L-002189-15	Resident Quality Inspection

Licensee/Titulaire de permis

LEAMINGTON UNITED MENNONITE HOME & APARTMENTS
22 Garrison Avenue LEAMINGTON ON N8H 2P2

Long-Term Care Home/Foyer de soins de longue durée

LEAMINGTON MENNONITE HOME LONG TERM CARE RESIDENCE
35 PICKWICK DRIVE LEAMINGTON ON N8H 4X5

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

TERRI DALY (115), ALICIA MARLATT (590), PATRICIA VENTURA (517)

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): April 27, 28, 29, 30, May 1, & 4, 2015

CIS C606-000002-15 inspected concurrently

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care, Director of Dietary and Support Services, Director of Social-Recreational Activities, Resident Assessment Instrument(RAI) Coordinator, three Registered Nurses, three Registered Practical Nurses, nine Personal Support Workers, the Occupational Therapist Aide, four family members, forty residents, and the Family Council Chair Person.

The Inspector(s) toured all resident home areas, observed dining services, medication storage rooms, medication administration, the provision of resident care, recreational activities, staff/resident interactions, infection and prevention control practices and reviewed resident clinical records, posting of required information, meeting minutes related to inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

5 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. 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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
b) complied with.

A review of the home's policy titled: "Fall Prevention and Management Program Policy" last revised in May 2011 revealed Registered Nursing staff were directed to conduct a fall risk assessment:

- Within 24 hours of admission
- Quarterly
- When a change in health status puts the resident at risk, such as:
- Two falls in 72 hours
- More than 3 falls in 3 months
- More than 5 falls in 6 months
- Significant change in health status
- Falls resulting in serious injury

The policy also stated Registered staff should:

- Initiate head injury routines for all unwitnessed falls.
- Complete an incident report including all contributing factors and forward a copy to the Fall Prevention Committee following every fall.

Resident #23 had sustained 2 falls and had a change in health condition. A health record review revealed Resident #23 did not have an fall risk assessment completed with a change in condition.

Progress notes and staff interviews for Resident #23 revealed the resident had an unwitnessed fall and staff did not complete a post fall incident report or complete a head injury routine following that fall.

A manager confirmed that Resident #23 should have received a fall risk assessment with change in condition and a post fall incident report and a head injury routine should have been completed following the unwitnessed fall as per the home's policy. [s. 8. (1) (a),s. 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 to ensure the homes "Fall Prevention and Management Program Policy" is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Interviews with management revealed a resident assessment and evaluation of the bed system to minimize the risk to the resident was not completed for Resident #23 while using a bed rail. Staff confirmed that where bed rails are used, a resident assessment and a bed system evaluation should be completed for all residents and this has not been conducted for any residents in the home to date. [s. 15. (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 to ensure where bed rails are used, all residents are assessed and all bed systems are evaluated to minimize risk to the resident, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

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

Inspectors each observed 6 fabric call bell cords in resident rooms. The observation revealed that discolouration and/or staining was noted for 9 of 18 or 50% of the fabric call bell cords.

A review of the homes Compliance Duties record for the month of April 2015 for the first floor - including the changing of call bell cords - revealed incomplete documentation for 4 of 8 days.

A manager confirmed that there is a process in place to ensure the call bell cords are checked and that the home is not following their process. [s. 229. (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 staff participation related to infection control practices required for cleaning of fabric call bell cords, to be implemented voluntarily.

WN #4: 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:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules are complied with:

All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked

During the initial tour of the home on April 27, 2015 a first floor door leading to an outside non secure area and a door leading to the Retirement Home which has an unsecure entry door were found unlocked.

On May 4, 2015 the door across from the Chapel was found unlocked and open to an outside non secure area.

All three of these doors have a keypad which requires a code to be entered to open the door and exit the building, but the system was not activated or was on bypass at the time.

A manager confirmed that these doors should be locked at all times. [s. 9. (1) 1. i.]

WN #5: 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

A health record review for Resident #24 revealed the resident had multiple pressure ulcers. A record review revealed weekly skin assessments were incomplete.

The home policy titled: "Skin Care and Wound Management Team" last revised December 2005 indicated:
"Weekly skin assessments shall be completed for all residents' wounds by Registered Staff as part of the Skin Care and Wound Management Policy and Procedure".

A manager and staff member verified Resident #24 did not have weekly skin assessments completed by a member of the registered staff while having altered skin integrity. The manager confirmed this resident should have received weekly skin assessments for altered skin integrity. [s. 50. (2) (b) (iv)]

Issued on this 11th day of May, 2015

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

Original report signed by the inspector.