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

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 8, 2016	2016_276537_0032	026318-16	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

BLENHEIM COMMUNITY VILLAGE
10 MARY AVENUE P.O. BOX 220 BLENHEIM ON N0P 1A0

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

NANCY SINCLAIR (537), NEIL KIKUTA (658), TERRI DALY (115)

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): August 29, 30, 31, September 1, 2, 6 and 7, 2016

The following intakes were completed within the RQI:
Log #035859-16/CI 2695-000014-15 related to allegations of abuse to a resident.
Log #019503-16/CI 2695-000008-16 related to allegations of abuse to a resident.
Log #017653-16/CI 2695-000010-16 related to responsive behaviours resulting in allegations of abuse to a resident.
Log #016728-16/CI 2695-000009-16 related to falls resulting in injury and transfer to hospital.
Log #019498-16/CI 2695-000007-16 related to falls resulting in injury and transfer to hospital.
Log #024639-16/CI 2695-000014-16 related to falls resulting in injury and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Assistant Director of Care, Food Services Supervisor, Registered Dietitian, Physiotherapist, Physiotherapy Assistant, one Cook, two Registered Nurses, five Registered Practical Nurses, one Wound Nurse, seven Personal Support Workers, one Recreation Aide, one Activation Aide, one Housekeeping Staff, Resident Council representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, reviewed policies and procedures, meeting minutes and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **2 WN(s)**
- **2 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. (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 ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

An identified resident had specific areas of altered skin integrity.

The plan of care for this resident identified a focus of a risk for impaired skin integrity and a goal to maintain skin integrity. Specific interventions were identified to meet the goal for the resident.

During observation of the resident on multiple days, the interventions to maintain skin integrity were not used.

The resident sustained a new area of impaired skin integrity.

During an interview with the Wound Care Nurse #115 and Registered Nurse #112 , both stated that the resident did not have the specific interventions in place. The Wound Care Nurse #115 placed the interventions immediately on the resident as per the plan of care. The Registered Nurse #112 stated that the interventions would be added to the Tasks in Point of Care to ensure that this intervention was completed and recorded daily by staff.

The Wound Care Nurse #115 stated that care had not been provided to the resident as per the plan of care. [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 the care set out in the plan of care is provided to the resident as specified in the plan, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system that was instituted or otherwise put in place was complied with.

The home's policy titled "Nutritional Care and Hydration" - CARE7-O10.05 effective date of August 31, 2016, outlined that "identified feeding and safe swallowing interventions are communicated to all members of the Interdisciplinary Team and documented in the Resident's plan of care."

An identified resident was observed during a meal service and a snack service being provided with a specific nutritional intervention.

Review of the resident's care plan identified risk factors related to nutritional intake and The Registered Dietitian (RD) had care planned and revised to ensure appropriate interventions were in place. The nutritional intervention noted in the DSR binder on the snack cart identified the interventions as per the care plan. The nutritional intervention that was observed being served to the resident was not as was identified in the care plan or DSR binder.

Registered Practical Nurse(RPN) #108 stated that resident was trialing alternate interventions after safety risks were identified. RPN #108 had sent a diet requisition identifying this intervention.

During an interview with the RD #118, the RD stated that they were unaware of the trial of this nutritional intervention and had not received a requisition or referral regarding the change.

During an interview with the Food Service Supervisor (FSS) #102, they stated that they also were unaware of the trial of this intervention . FSS #102 explained that requisitions and referrals were managed by the FSS, and that requisitions and referrals for any diet or texture changes would be forwarded to the RD. FSS #102 stated that they were responsible for updating the DSR binders for any diet or texture changes, and acknowledged that any changes should have been communicated to the RD for assessment.

The FSS stated that expected communication had not been completed 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 that any plan, policy, protocol, procedure, strategy or system that is instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.