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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 12, 2014	2014_257518_0035	L-001014-14	Resident Quality Inspection

Licensee/Titulaire de permis

MERITAS CARE CORPORATION
567 VICTORIA AVENUE, WINDSOR, ON, N9A-4N1

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

CHATEAU PARK LONG TERM CARE HOME
2990 B RIVERSIDE DRIVE WEST, WINDSOR, ON, N9C-1A2

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

ALISON FALKINGHAM (518), CAROLEE MILLINER (144), ROCHELLE SPICER (516)

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 12-19, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, Dietary staff, Business Office Manager/Environmental Manager, Activation staff, Registered staff, Personal Support Workers, residents and resident family members.

During the course of the inspection, the inspector(s) reviewed clinical records, policies and procedures, observed general and specific resident care, observed several meal services and activity programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 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 when there bed rails are used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

The home had a Facility Entrapment Assessment Audit completed 11 April 2014 by an external company.
It was observed that 17 beds had not had the bed system evaluated with or without a resident in them.
All of the above mentioned beds had one or two bed rails in the up position during these observations.
This was confirmed by the Administrator and the Director of Care.

The Administrator and Director of Care confirmed it is their expectation that all residents are assessed and their bed systems evaluated to minimize resident risk. [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 that the residents are assessed and their bed systems are evaluated in accordance with evidenced-based practices and, if thee are non, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are monitored during meals, including residents eating in locations other than dining areas.

On three occasions a resident was observed eating lunch unsupervised in their room from bed.
The resident confirmed they eat lunch without supervision every day.
Two registered staff confirmed the resident eats meals unsupervised in their room.

The Administrator acknowledged their awareness of this legislative requirement. [s. 73. (1) 4.]

2. The licensee failed to ensure proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

One staff was observed standing while assisting two residents to drink fluids from a glass.
The staff member confirmed this practice was not the appropriate method to provide fluids to residents. [s. 73. (1) 10.]

3. The licensee failed to ensure staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

One staff was observed assisting three residents between two tables, with eating and drinking at the same time.
The staff member identified this was a common practice so that residents do not have to wait a long time for their meal.

The Administrator acknowledged this was not an appropriate practice. [s. 73. (2) (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 that all residents are monitored during meals, that all staff use proper techniques to assist residents with eating, including safe positioning of residents who require assistance and that no person simultaneously assists more than two residents who need assistance with eating and drinking, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On two occasions the nursing computer program system located at the nurses desk, was observed to be left open to a residents clinical record.

One staff member and two management personnel confirmed staff are required to log out of the computer system when leaving the desk area. [s. 3. (1) 8.]

WN #4: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 failed to ensure the plan of care for a resident sets out clear directions to staff and others who provide direct care to the resident regarding her use of bed rails.

Two assessments and a physiotherapy progress note identifies the resident has a history of falls and their risk of falls is high.
The quarterly assessment identifies the resident has short term memory problems, a cognitive performance scale of 2/6 and uses one half bed side rail.
The written plan of care for bed mobility stipulates the resident is not at high risk of falls and that one half or partial bed rail is used when the resident is in bed.
The written plan of care for falls further includes directives for the use of two bedside rails when the resident is in bed.

Two staff interviews confirmed one bedside rail is used when the resident is in bed. [s. 6. (1) (c)]

2. The licensee did not ensure the plan of care is based on an assessment of the resident's needs and preferences.

The written plan of care for a resident related to bed mobility identifies the resident has requested two bed side rails be used so they feels more comfortable and that one bed side rail is utilized when the resident is in bed.

The written plan of care related to falls, includes a request for the use of two bedside rails.
When interviewed the resident confirmed that one bed side rail is used and that they prefers two side rails be used when in bed.

Two staff confirmed one bed side rail is used when the resident is in bed and that the resident is capable of communicating their needs and preferences. [s. 6. (2)]

3. The licensee failed to ensure the care set out in the plan of care is provided to the resident as specified in the plan.

A resident is visually impaired and ambulates independently with a walker.
The resident is at high risk for falls and experienced a fall previously.
The written plan of care directs that the resident is to wear non-skid footwear.
Twice the resident was observed ambulating with their walker wearing slippers without non-skid soles.

Two registered staff confirmed the resident was not wearing non-skid footwear as identified in the written plan of care. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The home failed to ensure the home, it's furnishing and equipment are kept clean and sanitary.

During the lunch meal observation the ceiling fan blades in the dining room were observed to have a thick layer of dust with strings of dust hanging over the edges of the blades.
During the same meal, the wallpaper on the back wall & the wall immediately to the right inside the door, was observed to be lifting.
On the same date, 4.5 inches of a decorative wood trim surrounding the dining room, was observed to be missing. [s. 15. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by a resident in the home unless the drug had been prescribed for the resident.

An inspector noted a bottle of liquid medication, without a pharmacy issued medication label on a resident bed side table.
The inspector was unable to locate a physician order or self-administration assessment record in the residents health record.

The Director Of Care confirmed the bottle of liquid medication was on the residents bed side table and that it should not have been there because the resident did not have a physician order for self-administration, the pharmacy had not been alerted and the resident had not had an assessment for self administration for the medication.

The Director of Care further confirmed the expectation is that residents rooms are monitored for the presence of medications and if a medication is found and has not been ordered for the resident, it is removed and the resident is informed of the homes process for self administration of medications.

The DOC provided the homes policy 6.10 Resident's Own Medication Supply which states:

To ensure the safe and effective use of medications, over-the-counter medication, herbal, homoeopathic and natural health products from the pharmacy. This will ensure appropriate packaging and labelling, proper documentation on the medication administration record, and the review of the resident's entire drug profile by the Pharmacist for drug interactions.

This policy also states "The resident's Physician should also be informed".

The Director of Care further reported she spoke with the resident in regards to the bottle of liquid medication found on residents bedside table. The Director of Care asked resident if they had taken any of the liquid medication today. The resident denied taking any of it today but did confirm they had taken this medication while in the home on previous occasions. The Director of Care also reported the bottle was empty and that the home was unaware that the resident had taken this medication on previous occasions. [s. 131. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs must be destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the director of nursing and personal care and one other staff member appointed by the director of nursing. This finding relates to sub-section (b) in every other case (than controlled substances).

The home's policy 8.1 "Non-Controlled Medication Destruction" was reviewed by the inspector. This policy did not state that destruction of non-controlled substances was to be done by a team acting together and composed of one member of the registered nursing staff appointed by the director of nursing and personal care and one other staff member appointed by the director of nursing.
This was confirmed by the Director of Care.

The Director of Care further confirmed the homes current process is that only one registered staff member has been destroying non-controlled substances. [s. 136. (3) (b)]

2. The licensee had failed to ensure that when a drug was destroyed, the drug was altered or denatured to such an extent that its consumption was rendered impossible or improbable.

The Director of Care reported the homes current practise only involves altering or denaturing controlled drugs for pick up by the homes disposal contractor. The Director of Care and Inspector viewed the disposal bin for non-controlled drugs and noted medication tablets and nebulizer ampules in their original form and/or packaging.
The Director of Care confirmed these drugs were not altered or denatured to such an extent that their consumption was rendered impossible or improbable.
The Director of Care further confirmed the home's current practice is to place non-controlled drugs in the disposal bin without destroying them for pick-up by the contracted disposal company. [s. 136. (6)]

Issued on this 26th day of September, 2014

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