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 4, 2014	2014_276537_0040	L-001048-14	Resident Quality Inspection

Licensee/Titulaire de permis

GROSVENOR HEALTH CARE PARTNERSHIP (NO. 4)
150 WATER STREET SOUTH, CAMBRIDGE, ON, N1R-3E2

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

COUNTRY VILLAGE HEALTH CARE CENTRE
440 County Road 8, R. R. #2, Woodslee, ON, N0R-1V0

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

NANCY SINCLAIR (537), ALICIA MARLATT (590), 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 18, 19, 20, 21, 22, 26, 28, 29, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Support Services Manager, Programs Manager, Registered Dietitian, Pharmacist, Dietary Aide, 1 Registered Nurse(RN), 9 Registered Practical Nurses(RPN), 9 Personal Support Workers(PSW), 41 Residents, and a Family Member.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas, recreational activities and care provided to residents, reviewed clinical records and plans of care for identified residents, reviewed policies and procedures and related training records, and observed general maintenance, cleaning and condition of the home.

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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
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. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that (c) a record of the annual care conference for a resident is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Review of the clinical record for an identified resident does not include documentation of an annual care conference for 2013 or for 2014.

A Registered Staff confirms that care conferences for an identified resident was held for 2013, and that a care conference was scheduled, canceled and to be rescheduled for 2014. A Registered Staff confirms that the clinical record does not include documentation of the care conferences indicating those in attendance or the results of the conference. The Director of Care indicates that the expectation is that a record will be kept of the annual care conferences for all residents. [s. 27. (1)]

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 a written record of the annual care conference for each resident is kept of the date, the participants and the results of the conference, to be implemented voluntarily.

WN #2: 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 where drugs that are to be destroyed and are not controlled substances are done so by a team acting together and composed of:
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

During drug storage observation a white container labeled as bio-hazardous was found containing numerous medications in their original state.
A Registered Practical Nurse explained that these containers are used to store medications for destruction, and picked up when full.

The Director of Care confirmed that all medications for destruction are placed into the drug destruction containers, supplied by the pharmacy, in the medication rooms. When the containers are full, a medical waste disposal company picks the containers up for destruction and disposal.

The homes Non-Controlled Medication Destruction Policy #8.1 indicates that a Drug Destruction Container is located in the med room. Once the container is full, it is sealed and set aside for removal by a designated waste disposal company. This policy contradicts the O.Reg. 79/10 s.136(3) that the drugs will be destroyed by a team acting together and composed of:
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

An interview with the Pharmacist reveals that the pharmacy is aware of the regulations and currently drafting policies and procedures to comply with the regulation. [s. 136. (3) (b)]

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

During drug storage observation a white container labeled as bio-hazardous was found containing numerous medications in their original state.

The Director of Care confirmed that the non controlled substance medications for destruction are placed into the drug destruction containers supplied by the pharmacy in the medication rooms. When the containers are full, a medical waste disposal company picks the containers up for destruction and disposal. She indicates that these drugs are not altered or denatured prior to pick up by the designated waste disposal company.

An interview with the Pharmacist reveals that the pharmacy is aware of the regulations related to the altering and denaturing medications and are currently developing processes to meet this regulation. [s. 136. (6)]

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, as part of the medication management system,that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of drugs and that where drugs that are to be destroyed and are not controlled substances are done so by a team acting together and composed of:
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, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care provides clear directions to staff and others who provide direct care to the residents.

The written plan of care and the MDS assessment for an identified resident indicates a communication deficit without any specific interventions in place. Observation of the resident and review of the clinical record indicates that the resident does have specific interventions and equipment to address the communication deficit. A Registered Staff and a Personal Support Worker confirm that there are specific interventions and equipment used by the resident that is not indicated in the written plan of care.

The home's policy, Care Planning, indicates the following: Ongoing, Registered Staff and other members of the interdisciplinary care team are responsible for updating the resident's plan of care to ensure it remains current and reflective of the care needs of the resident at any given point in time.

The Director of Care confirms that it is the expectation that the resident's plan of care provides clear direction to staff and others who provide direct care to a resident. [s. 6. (1) (c)]

WN #4: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Infection Prevention and Control program is evaluated and updated at least annually.

The Director of Care was unable to produce written documentation to support that an evaluation has been completed on the Infection Prevention and Control program within the last year. The Director of Care confirmed that an annual evaluation has not been completed for the Infection Prevention and Control Program within the last year and that an evaluation of the Infection Prevention and Control program should be completed annually. [s. 229. (2) (d)]

2. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

An identified resident admitted to the Home has no documentation to support that a 2 Step Mantoux test was administered or a chest xray was completed within 14 days of admission.
Documentation of a second identified resident admitted to the Home revealed that the first step of the Mantoux TB skin test was administered but not evaluated at the appropriate time. The second step was not administered. There was no documentation to support that a chest xray was completed at any time.

The Director of Care confirmed that TB screening and evaluation for the identified residents was not completed or documented as required. [s. 229. (10) 1.]

Issued on this 8th day of September, 2014

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