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
Apr 14, 2015	2015_349590_0008	L-2030-15	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 Homes - Woodslee
440 County Road 8 R. R. #2 Woodslee ON N0R 1V0

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

ALICIA MARLATT (590), ALISON FALKINGHAM (518), JOAN WOODLEY (172), 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): March 16, 17, 18, 19, 20, 25, 26 and 27, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Program Manager, a Pharmacist, the Food Services Manager, the Maintenance Manager, President of the Residents' Council, a member of the Residents' Council, two Activation Aides, five Registered Nurses, nine Registered Practical Nurses, sixteen Personal Support Workers, 40+ Residents and three Family members.
During the course of the inspection, the inspector(s) observed dining services, medication rooms and administration, the provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices and reviewed resident clinical records, posting of required information, meeting minutes relevant to inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Skin and Wound Care

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

3 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 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 failed to ensure that the plan of care sets out clear directions to staff and others who provide care to the resident.

Interviews with three staff members revealed that Resident #002 does not require transfer to a commode via a mechanical lift for toileting, however, care plan details indicate that this resident is toileted on the commode via the use of a toileting sling.

Resident #002 has a stated preference for oral care. Three staff interviews reveal that the resident receives care as requested, however the resident's care plan does not include instructions for oral care to provide direction to care staff.

The Director of Care confirmed that the expectation is that care plans reflect actual care and should provide clear directions to staff and other who care for residents. [s. 6. (1) (c)]

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 plan of care sets out clear directions to staff and others who provide care to the resident, 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #001 stated that they had increasing episodes of bowel incontinence.
The (Multiple Data Set) MDS indicated that the resident was usually continent and the subsequent MDS assessment indicated that the resident was occasionally incontinent.
Review of this resident's assessments revealed that an incontinence assessment was completed on admission but no further assessments for incontinence were completed.
The Continence Management Policy RESI-10-04-01 last revised November 2013 indicates that a continence assessment will be completed on admission, with a deterioration in continence level and with any change in condition that might affect bowel and bladder continence.
Interviews with three registered staff members indicate that they had not completed these assessments as set out in the policy.
The Director of Care confirmed it is the expectation that all Registered Staff members are aware of and follow the home's policies. [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #005 was observed for a three day period to have unclean nails. Over this 3 day period the resident had received morning care three times, a regularly scheduled bath/shower and a manicure from an Activity Aide. The resident was observed on the last

day of observation and the nails remained unclean.
Interviews with two Personal Support Workers at the bedside confirmed that this resident did have their bath and a manicure and that the residents nails were still dirty.
The Personal Hygiene/Grooming Policy RESI-05-07-23 revised August 2005 indicates that a resident will be offered two baths/showers per week and that bath/shower will include cleaning and trimming of finger and toe nails, Registered Staff will review the Daily Care records weekly to ensure that finger and toe nail care was provided, the Personal Support Worker will document this care on the daily care record.
The Director of Care confirmed that this policy was not followed for Resident #005 and the expectation is the policy regarding bathing and nail care be followed at all times by all staff. [s. 8. (1) (b)]

3. The licensee failed to ensure that any plan, policy, procedure, strategy or system instituted or otherwise put in place was complied with.

On March 25, 2015, the Inspector and Director of Care (DOC) observed the Medication Cart storage area for the Meadowview home area.

1) There was a pill bottle with several different shapes, sizes and colours of pills/capsules inside. The DOC shared this bottle contained medications that were to be destroyed.
The LTCH's Policy No. 8.1, titled, Non-Controlled Medication Destruction indicates:
The home shall ensure that until surplus medication is destroyed and disposed of, they are stored safely and securely within the home, separate from medication that is available for administration to a resident.
The Director of Care confirmed the medications in the pill bottle were being kept within the medication cart which contains medication that is available for administration to residents.

2) The as needed (PRN) medications packaged by the LTCH's pharmacy service provider were observed in the medication cart. On the back of the blister packages, there is a box for documenting the expiry date and lot # of the medication when these are dispensed from the original container into the blister pack by the Pharmacist.
The Inspector and Director of Care observed a blister pack of Quetiapine 25mg, dispensed February 10, 2014. This blister pack of medication did not have a documented expiry date or lot #.
The Inspector and Director of Care observed a blister pack of Risperidone 0.5mg, dispensed November 06, 2013. This blister pack of medication did not have a documented expiry date or lot #.

The LTCH's Policy No. 3.14, titled, "Medication Management Audit" indicates:
To assist each home with it's risk management and quality improvement activities, the pharmacy staff will conduct quarterly scheduled audits to ensure compliance with the applicable regulations, accreditation standards, professional standards of practice and other governing bodies.
The procedure for this policy indicates:
Medication management audits will include but may not be limited to the following - management of discontinued and expired drugs.
The Director of Care confirmed the staff would be unable to determine and manage expired medications if the medication packaging did not have expiry dates listed.

3) The following medications had direction changes hand written on the blister packages that these medications were dispensed in:
Risperidone 0.5mg, had a pharmacy issued label which stated “Take one tablet extra per 24 hour period in addition to regular dosing". Hand written on this blister pack was a direction change “PRN changed 0.25mg ½ tab dated December 17, 2014".
Quetiapine 25mg, had a pharmacy issued label which stated “Take one tablet by mouth every 4 hours as required". Hand written on the blister pack was a direction change which stated “increase to two tabs every 4 hours dated October 29, 2014".
The LTCH's Policy No. 3.11, titled, Medication Labels indicates:
All medication must remain in the original labelled container or package provided by the pharmacy service provider. Labels may not be affixed to a medication or altered by anyone other than a pharmacist.
The LTCH's Policy No. 4.14, titled, Documentation of an Order Change indicates:
An order change may include a change in drug, dosage form, dose, frequency or directions for use of an existing medication order. When an existing medication order is changed, it must be discontinued and the changed order documented/processed as a new order.
The procedure section of this policy indicates:
Pharmacy will send any required medications to accommodate the change in the medication order.
The Director of Care and Administrator confirmed the home was not following their policy. [s. 8. (1) (b)]

4. The licensee failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On March 25, 2015, the Inspector and Director of Care observed medications being stored in the medication cart on the Meadowview Home Area. We observed a box of the medication Spiriva containing 12 doses that was no longer labeled with the original pharmacy label. The top of the box had been torn off. The Director of Care confirmed this medication should have a pharmacy issued label in place.
The LTCH's Policy No. 3.2, titled, "Medication Packaging" indicates:
All resident medication must remain in the original labeled container or package provided by the pharmacy.
The Director of Care confirmed the LTCH's expectation that pharmacy labels should not be removed from the medication. [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 instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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 with altered skin integrity, including skin break down, pressure ulcers, skin tears or wounds, have been reassessed weekly by a member of the registered staff.

Resident #006 has documented wounds.
The Physician's orders reveal that there are orders for weekly observation of these wounds and treatments for these wounds.
Review of Assessments for a two and a half month period revealed that although each wound had at least one complete wound assessment there was no documentation to indicate the wounds were reassessed weekly by a registered staff member.
The above findings were confirmed by the Wound Care Lead.
The Director of Care confirmed the expectation is that all wounds are observed and recorded on a weekly basis by the Registered Staff. [s. 50. (2) (b) (iv)]

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 resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member or the registered nursing staff, using a clinically appropriate that is specifically designed for skin and wound assessment, to be implemented voluntarily.

Issued on this 16th day of April, 2015

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

Original report signed by the inspector.