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

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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
Oct 21, 2015	2015_219211_0015	T-1658-15	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

EAGLE TERRACE
329 EAGLE STREET NEWMARKET ON L3Y 1K3

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

JOELLE TAILLEFER (211), NICOLE RANGER (189), SHIHANA RUMZI (604)

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): July 29, 30, 31 and August 4, 5, 6, 7, 10, 11, 2015.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Environmental Service Manager (ESM), Staff Development Coordinator, Registered Dietitian (RD), Registered Nurses (RN), Physiotherapist, Wound Care Champion, Continence Program Lead, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Laundry aide, Housekeeping aide, Residents' Council President, Family Council Representative, Residents and Family members.

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

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **1 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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area of the medication cart that is used exclusively for drugs and drug related supplies.

On an identified date, during observations of a medication cart on an identified home area, the inspector observed non drug-related items being stored in the medication carts and the double locked narcotics bins. These items included a personal cheque and one unidentified resident's pair of eyeglasses. Staff interview with the registered staff #105 and the Director of Care (DOC) confirmed that the medication cart is to be used exclusively for drugs and drug related supplies only and should not have items stored in the medication cart. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date and time, the inspector observed an unattended medication cart to be stored outside the dining room during breakfast on an identified home area. The medication cart was left open, as the inspector was able to open the drawers of the medication cart.

RPN #103 confirmed that the medication cart was unlocked and was accessible to anyone passing by and did not follow the home's expectation in keeping the medication stored in a locked medication cart.

Interview with the DOC confirmed that medication carts are to be kept locked at all times when not in use and RPN #103 was not following safe medication practices in keeping the medication cart locked. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area of the medication cart that is used exclusively for drugs and drug related supplies, to be implemented voluntarily.

WN #2: 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. (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 written plan of care sets out clear directions to staff and others who provide direct care to the resident.

Review of the written plan of care on an identified date, indicated that resident #004 is using bed rails for mobility.

Review of the progress notes on an identified date, indicated that both side rails were removed with the family's consent.

Review of the progress notes on an identified date, indicated that the resident had an un-witnessed fall where the resident rolled off his/her bed onto the floor.

Observation made on an identified date, by the inspector noted that the right side bed rail was in the up position and fall mat was placed on the right side of the bed.

Interviews conducted with Personal Support Worker (PSW) #111, Registered Nurse (RN) #112 and the DOC confirmed that the resident is using only the right side rail and the fall mat when he/she's lying in bed since the fall on the identified date. RN #112 and the DOC confirmed resident #004's written plan of care and the current Kardex does not set out clear direction to staff and others who provide care to the resident indicating to elevate the right side rail and put a fall mat when resident is in bed. [s. 6. (1) (c)]

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

Record review for resident #006 revealed that the resident had an un-witnessed fall on an identified date.

The written plan of care for resident #006 states the resident is a medium risk for falls and a identified logo is used to identify the resident as high or immediate risk.

On an identified date, the inspector observed no logo located in the resident room or above the bed to identify the resident is at risk for falls.

Interviews with Personal Support Worker (PSW) #109 , PSW #118, Physiotherapist (PT) #107, RN #105 and RN #117 confirmed that the resident is high risk for falls. RN #105 observed and confirmed that there is no logo located in the resident room or above the bed to identify the resident is at risk for falls and immediately placed a logo above the bed. [s. 6. (7)]

3. Resident #002's bath days are on two identified days as indicated on the Point Click Care (PCC) task section.

Observations carried out for resident #002 on three identified days, revealed the resident's fingernails were long with brown dirt caked underneath the nails.

Written plan of care under bathing focus indicated finger/toe nails to be trimmed on bath days.

On an identified date, the resident's fingernails were noted to be long with brown dirt under his/her fingernails. Interview with resident #002 revealed that he/she had a bath the previous day, but does not remember getting his/her fingernails cut or cleaned.

Interviews with PSW #111 and the DOC confirmed resident #002's fingernails were not trimmed or clean. The DOC confirmed resident #002 did not receive care as set out in the plan of care. The DOC had PSW #111 clean the resident's fingernails immediately. [s. 6. (7)]

4. During a review of resident #002’s written plan of care, the inspector noted an

identified intervention to be implemented every shift.

Observations carried out on several occasions on two identified dates, failed to reveal the identified intervention.

Electronic Treatment Administration Record (ETAR) for the two above identified days, was signed off as care provided to resident by registered staff.

The DOC confirmed resident #002 did not have the identified intervention in place and care was not provided as indicated in the resident's written plan of care. [s. 6. (7)]

WN #3: 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 instituted or otherwise put in place is complied with.

Record review of resident #006 revealed that the resident had an un-witnessed fall on an identified date.

A review of the home's policy entitled "Interprofessional Clinical Programs, Fall Interventions Risk Management Program Documentation/Monitoring", LTC-E-60, revised March 2014, revealed that if a fall is not witnessed or the resident has hit his/her head, the neurological assessment will be initiated and completed for 72 hours. The frequency for completing the Head Injury routine according to the home's policy was as follows:

every 30 minutes x 2 hours, every 1 hour x 6 hours, every 4 hours x 8 hours, and every 8 hours x 56 hours for a total of 72 hours total monitoring.

Review of resident #006's neurological assessment record for the fall on an identified date, revealed that the assessment was not completed on the next day for 2:15 a.m., 3:15 a.m., and 4:15 a.m.,(instructed to be completed every hour) and at 12:15 p.m., (instructed to be completed every 4 hours for 8 hours).

Interview with RN #117 confirmed that neurological assessment for resident #006 was not completed for the above time period. [s. 8. (1) (a),s. 8. (1) (b)]

2. The home's policy Medication/Treatment Standards, Drug Destruction and Disposal for Non Narcotic and Non Controlled Drugs – Ontario only, LTC-G-218-ON, effective September 2010, procedure 8, directs the registered staff on a routine basis (monthly and/or as per need), medication for destruction is collected from the secured storage areas and moved to a designated medication waste disposal box/container by a designated team comprised of one registered staff and one other staff member.

On an identified date, the inspector observed substantial amount of discontinued and refused medications in the medication room cupboard on an identified home area. The inspector reviewed the medications and noted discontinued medications from April, May and June 2015.

The inspector reviewed the home's non narcotic and non controlled medication destruction record which indicates that the last date of destruction of the medication units on three identified home areas was completed on March 20, 2015.
Interviews with registered staff #105 and the DOC confirmed that the non narcotic medication destruction is completed on a one to two month basis, and the last non narcotic medication drug destruction was completed six months ago. The DOC and registered staff #105 confirmed that the medication for destruction was not collected from the secured storage areas and moved to a designated medication waste disposal box/container as per home's policy. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The written plan of care for resident #006 indicates that the resident requires support for bathing due to specific health issues. The plan of care indicates that the resident's scheduled bath days are on two specific days and times.

A review of the resident's bathing record for two specific months, revealed that resident #006 did not receive the minimum of two baths on three specific days.

Interview with the DOC reported that in the event that resident does not receive their bath on their scheduled day, the expectation is that the resident will receive a make-up bath the next day as well as the next regular scheduled bath. Interviews with PSW #101 and the DOC confirmed that the resident did not receive the scheduled baths on the above dates. [s. 33. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails.

On an specific day, the inspector observed resident #006's fingernails to be unclean and untrimmed. The resident was scheduled to have a bath on an specific day. The inspector observed the resident's fingernails for a period of four days on which the resident's fingernails continued to be in the same manner and visibly unclean.

Review of resident #006's written plan of care indicates that the resident's scheduled bath days are on two specific days and times. The plan of care indicates that nails are manicured and trimmed on bath days.

Interviews with PSW #109 revealed that residents nails are cleaned and trimmed on the resident's bath days by the staff as per home process.

Interviews and observations of resident #006 fingernails by the DOC and PSW #109 on a specific date, confirmed that the resident's fingernails are untrimmed and does not appear to be cleaned by the staff. [s. 35. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an

assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Review of the resident #011's written plan of care indicated the resident is incontinent as evidenced by frequently incontinent due to specific health issues.

Review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) indicated the resident is continent of bowel and bladder.

Observations and review of the Prevail list indicated resident #011 wears an identified continence product on days, evenings, and nights.

Review of Assessment section on point click care (PCC) failed to reveal an incontinence assessment for the resident was carried out.

Interviews conducted with RPN #121 and the DOC confirmed the home does not have an incontinent assessment instrument and home only utilizes the 14 day incontinent diary/flow sheet to assess incontinence for residents.

DOC #108 informed the inspector the past incontinent assessment instruments were retired and corporate is in the process of creating a incontinent assessment instrument. [s. 51. (2) (a)]

2. Review of the RAI-MDS on an identified date, indicated resident #003 tended to be incontinent every day, but has some control. Review of the MDS after two months, indicated that the resident is incontinent multiple times on a daily episode and there was deterioration in continence.

Review of the section " Assessment" in the Point Click Care (PCC) and interviews with RN #117 and the DOC revealed that the resident did not receive a continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence when the next MDS on an identified date, indicated a continence deterioration.

Interview with the DOC confirmed that the licensee does not have a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence that

includes identification of causal factors, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

WN #7: 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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

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

During observations conducted during meal service on an identified date, the inspector observed PSW #115 assisting resident #014 with the meal. Resident #014, who has a medical history of specific health issues remained in a titled position while being fed with the resident's head tilted to the side. While feeding the resident, the inspector observed PSW #115 forcefully place a hand on the resident's face and push the resident's face upright prior to feeding the resident. PSW #115 was observed on three occasions during the meal service to feed the resident in this manner.

Interview with RN #105 who was present in the dining room, confirmed that PSW #115 did not use proper techniques to assist resident #014 with the meal. [s. 73. (1) 10.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Review of the home's Complaint Management Program binder for 2014 and 2015 did not reveal a Client Services Response Form (CSR) had been completed for resident #009's two lost items.

Interviews held with two of resident #009's family revealed that the resident's one item went missing in 2014 and the other resident's item went missing in 2015. Interview with the family revealed that the home's staff were informed of the missing items on both occasions.

Interviews with PSW # 127, RN #112, and the DOC revealed that the resident's one item went missing a few months ago.

Interviews with PSW #127, Laundry Aide #128 and Housekeeping Aide #129 revealed the resident's one item was sent to the laundry to be labelled. The item was labelled with the resident's name on an specific date and sent back to the appropriate floor after two days.

A search was immediately started when the family reported the lost items.

Interview with the Environmental Services Manager (ESM) revealed that an investigation was started when he/she was informed of the one lost item by the family, but the Client Service Response (CSR) was not initiated and completed.

Review of the home's policy index LP-B-20 titled "Management of Concerns/Complaints/Compliments" dated October 2014, indicated if a complaint cannot be resolved immediately at point-of-service, the individual who is first aware of a concern will initiate the Client Service Response (CSR) form and forward to the Executive Director (ED). The CSR form is to be completed in full and all actions taken during the investigation is to be documented. The CSR is then filed in the complaints management binder.

Interview with the ED confirmed CSRs were not completed for the missing items. [s. 101. (2)]

WN #9: 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. (1) Every licensee of a long-term care home shall ensure, 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,
(a) all expired drugs; O. Reg. 79/10, s. 136 (1).
(b) all drugs with illegible labels; O. Reg. 79/10, s. 136 (1).
(c) all drugs that are in containers that do not meet the requirements for marking containers specified under subsection 156 (3) of the Drug and Pharmacies Regulation Act; and O. Reg. 79/10, s. 136 (1).
(d) a resident's drugs where,
(i) the prescriber attending the resident orders that the use of the drug be discontinued,
(ii) the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician, or
(iii) the resident is discharged and the drugs prescribed for the resident are not sent with the resident under section 128. O. Reg. 79/10, s. 136 (1).

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the medication management system, a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs.

The home's policy "Medication Treatment Standards, Drug Destruction and Disposal for Non Narcotic and Non Controlled Drugs", LTC-G-218-ON procedure 3, revised September 2010, directs the registered staff to identify any medication for disposal on an ongoing basis (suggested weekly) by checking for expired medication. Non narcotic and non controlled drugs for destruction are removed from all medication storage areas and retained in a secure area in the locked medication room for future drug destruction.

On an identified date, the inspector observed medication expired on an specific month for resident # 017 and an identified government stock medication that expired in May 2015, in the medication cart on an identified home area.

Interviews with the DOC and RN #105 confirmed that the expired medications was not discarded and routinely checked by the registered staff as per the home's policy. [s. 136. (1)]

2. The licensee has failed to ensure that the home's drug destruction and disposal policy include that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substances that is available for administration to a resident, until the destruction and disposal occurs.

The home's narcotic drug destruction process directs the registered staff that all controlled substances which are to be destroyed are always stored in a designated area separate from any controlled substances that is available for administration to a resident and maintained under double lock until the destruction and disposal occurs.

On an identified date, the inspector observed a discontinued narcotic card with two narcotic pills intact in the package for resident #015 in the double locked narcotic box inside the medication cart that was not separate from controlled substance available for the resident. The discontinued narcotic was also observed in the current narcotic bin.

Interviews with the DOC and RN #105 confirmed that the expired medications was not stored in a double locked storage area, separate from any controlled substances that is available for administration to a resident, until the destruction and disposal occurs as per process. The home's expectation is the discontinued narcotic medication is stored in the double locked box in DOC office. [s. 136. (2) 2.]

WN #10: 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 has failed to ensure that all staff participate in the implementation of the program.

On an identified date and time, the inspector observed medication administration for three separate residents by registered staff #103. The RPN did not perform hand hygiene before or after the administration of the medications to either of the residents, and during one administration of medication to a resident, the RPN was observed not to practice hand hygiene or wear PPE when administering medication to a resident who was on contact precaution. After administering the medication, the RPN came out of the room and proceeded to assist another resident without performing hand hygiene. The RPN #103 confirmed to the inspector that he/she did not perform hand hygiene after medication administration. [s. 229. (4)]

2. On an identified date, the inspector observed two personal care items belonging to resident #013 located in resident #006's washbasin, stored in the bathroom that is shared by other residents.

Interview with PSW #104 confirmed that resident #013's personal items should not be stored in another resident's washbasin which thereby potentially exposing resident to infection. [s. 229. (4)]

Issued on this 4th day of November, 2015

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

Original report signed by the inspector.