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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 3, 2012	2012_179103_0014	O-001610-12	Complaint

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

FOSTERBROOKE
330 KING STREET WEST, NEWCASTLE, ON, L1B-1G9

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 13, 14, 2012

During the course of the inspection, the inspector(s) spoke with a Family member, Personal support workers, Registered Nurses, an Enterostomal therapist (ET), a Nurse Consultant, Registered Practical Nurses, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) completed a walk through of the home, reviewed resident health care records, and the home's Skin and Wound care policy.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 50 (2) (a) (i) whereby a resident did not receive a skin assessment within twenty four hours of admission.

Resident #1 was admitted to the home for a short stay admission. A family member of Resident #1 declined to have the dressings observed at the time of admission because the dressings had been changed in the morning. A skin assessment was completed on Point Click Care for Resident #1 on a specified date and included the measurements of Resident #1's wounds.

In an interview with the Administrator, she confirmed the measurements had been taken from the wound care instructions provided to the home by the community ET nurse and that registered nursing staff had not completed a skin assessment within twenty four hours of admission for Resident #1. [s. 50. (2) (a) (i)]

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 short stay residents have a skin assessment completed by registered nursing staff within 24 hours of the resident admission, 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 comply with O. Reg. 79/10 s. 8 (1) as required under O. Reg 79/10 s. 30 (1) 1, in that the required program for skin and wound care and the relevant policies related to wound assessment and documentation were not complied with.

The home's Skin and Wound Care Policy, LTC-N-20, under "Documentation" states, a Treatment Observation Record (TOR) will be initiated when a Resident has any open area involving the dermal layer and deeper. One TOR is completed per wound. A TOR is completed by the Nurse with every dressing change.

A Treatment Observation Record includes the following wound care information:
-wound location
-size of wound
-evidence of infection
-appearance of wound bed
-exudate
-present treatment.

Resident #1 required daily dressing changes. A Treatment Observation Record was not initiated or completed at any time during Resident #1's short stay admission. [s. 8. (1)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

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1. The licensee failed to comply with LTCHA s. 23 (2) whereby the results of an alleged neglect investigation was not reported to the Director.

Administrator, Charlene Smith submitted a mandatory report to the Director to report an alleged incident of staff to resident neglect. Smith advised the investigation was completed on an identified date. To date of the inspection, the Director was not advised of the outcome of the home's investigation into the alleged neglect. [s. 23. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, s. 24 (1) (2) whereby the Director was not immediately informed of an incident of alleged neglect of a resident.

On an identified date, the Manager of Client Relations for Revera Long Term Care, Inc., received a telephone call from the family member of Resident #1 and alleged Fosterbrooke Long Term Care Home neglected the family member during the short stay.

The Director was not informed immediately of the alleged neglect of the resident. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 24 (9) (a) whereby a resident with a change in care needs was not reassessed.

On an identified date, Resident #1 was admitted to the home. The following day, Resident #1 experienced an identified change in condition which was documented over a three day period.

Throughout the identified time period, there was no documented evidence of reassessment for Resident #1's change in condition. [s. 24. (9) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 30 (2) whereby assessments, reassessments, interventions and the resident's responses to interventions were not documented.

During the admission of Resident #1, the home was advised of the resident's required repositioning schedule.

During Resident #1's short stay admission, the home failed to consistently document the following care provided to Resident #1:
-repositioning provided
-bathing, personal care and
-continence care. [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 68 (2) (d) whereby a resident with identified risks related to nutrition and hydration did not have their food and fluid intake monitored.

Resident #1 was on a prescribed diet and was deemed to be at high nutritional risk.

On identified dates, the fluid intake records were incomplete and there was conflicting documentation related to the resident's dietary intake. [s. 68. (2) (d)]

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. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 101 (1) 1 whereby a verbal complaint which alleged harm to a resident was not immediately investigated.

On an identified date, the home was notified of an alleged staff to resident neglect.

According to the Administrator, the investigation into this matter was not initiated until the following day. [s. 101. (1) 1.]

Issued on this 3rd day of December, 2012

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