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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Aug 5, 2016	2016_206115_0025	020802-16	Resident Quality Inspection

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

HERON TERRACE LONG TERM CARE COMMUNITY
11550 McNorton Street WINDSOR ON N8P 1T9

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

TERRI DALY (115), ALICIA MARLATT (590), CAROLEE MILLINER (144), INA REYNOLDS (524)

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 18, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2016

The following intakes were completed within the RQI:
017322-15 Critical Incident 2898-000013-15 related to alleged financial abuse
018427-15 Critical Incident 2898-000014-15 related to dietary issues
028760-15 Critical Incident 2898-000025-15 related to alleged staff to resident abuse

022124-15 Critical Incident 2898-000018-15 related to a fall
034529-15 Critical Incident 2898-000026-15 related to an injury with hospitalization
007913-16 Critical Incident 2898-000005-16 related to alleged resident to resident abuse
011029-16 Critical Incident 2898-000010-16 related to missing narcotics
011443-16 Critical Incident 2898-000012-16 related to a fall

The following intakes were inspected at the same time as the RQI and can be found in a separate report(s):
035200-15/034307-15 Complaint letter/Critical Incident 2898-000028-15 related to resident care
001745-16 IL-42604-LO Complaint/Critical Incident 2898-000001-16 related to responsive behaviours
005782-16 IL-42450-LO Complaint related to resident care
008807-16 IL-43658-LO/IL-44227-LO Complaint related to dining and snack policies
009415-16 IL-43611-LO Complaint related to nutrition
012405-16 IL-44065-LO Complaint related to sufficient staffing
011027-16 IL-44110-LO Complaint related to resident care
014600-16 IL-44387-LO/IL44388-LO Complaint related to resident care
019282-16 IL-44887-LO Complaint related to misuse of funding

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care(MRC), the Director of Clinical Services and Education, the Registered Nurse/Resident Assessment Instrument(RN/RAI) Coordinator, the Manager of Food Services, a Registered Dietitian, one Dietary Aide, a Ward Clerk, the Payroll Scheduler, two Life Enrichment staff, two Nurse Practitioners(NP), six Registered Nurses(RN), eleven Registered Practical Nurses (RPN), 16 Personal Support Workers(PSW), the Resident Council Representative, Residents and Families.

The inspector(s) also conducted a tour of all resident areas and common areas, observed residents and care provided to them, meal service, medication passes, medication storage areas, reviewed health care records and plans of care for identified residents, policies, procedures, programs and associated training, minutes from meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **2 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

Resident #041 was observed in bed with one side rail in the up position.

Review of resident #041's documentation revealed a "Resident Mobility and Bed Rail Assessment" had been completed. The assessment recommended that the resident use both side rails for safety. A review of the resident's current care plan indicated the resident used one rail only.

During an interview with the Manager of Resident Care(MRC) #105 and RN/RAI Coordinator #103 both staff said that there was a discrepancy in documentation, that the assessment was documented correctly, and that the care plan had not been updated to reflect the outcome of the assessment. [s. 6. (2)]

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 the plan of care is based on an assessment of 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #043 had been hospitalized.
A progress note, indicated the hospital had contacted the home to notify them of resident #043's MRSA status. The Inspector could not locate any documentation to support that MRSA/VRE swabs had been completed within 24 hours of when the resident returned to the home post hospitalization.

The home's policy Methicillin Resistant Staphylococcus Aureus (MRSA), policy number ICM 07-03 and last revised on November 19, 2015, indicated in the procedure section for screening of residents on admission and readmission that "All residents upon return from hospital after a 12 hour stay, will have anterior nasal, peri anal or groin, invasive device sites and any open areas swabbed within 24 hours of readmission (if the resident is readmitted on a Friday, Saturday or Sunday then swabs will be done on Monday). Document in the progress notes."

The home's policy titled Vancomycin Resistant Enterococci (VRE), policy number ICM 07 -04 and last revised on November 19, 2015, indicated in the procedure section for screening of residents on admission and readmission that "All residents upon return from hospital after at least a 12 hour stay, will have a rectal swab/stool specimen done within 24 hours of readmission (if the resident is readmitted on a Friday, Saturday or Sunday then swabs will be done on Monday) and documented in the progress notes."

During an interview the RN/RAI Coordinator #103 said that any resident returning from the hospital after admission was supposed to have MRSA and VRE swabs completed within 24 hours of returning to the facility, and that resident #043 had not been screened for MRSA/VRE when returning to the home as required by the homes policy. [s. 8. (1)]

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

The home's contracted pharmacy Classic Care's policy related to Administering PRN Medication, policy number 4.4 revision date March 2009 indicated the following: Frequent use of a PRN medication may suggest that a routine order may be warranted. In such cases, the resident's physician should be contacted for reassessment.

Review of the resident's clinical record revealed:

Resident #022, was prescribed administration of a narcotic analgesic medication, PRN for pain.
During a time period, the PRN analgesic was administered as ordered for resident #022 on 49 occasions.
- On 40 occasions, the medication effect was documented on the Electronic Medication Administration Record(E-MAR) as being effective
- On 2 occasions, the medication was documented as ineffective
- On 3 occasions, the medication effect was coded as unknown
and
- On 4 occasions, the medication effect was not documented.

From July 1 to July 24, 2016, the PRN analgesic was administered to resident #022 as ordered on 50 occasions.
- On 47 of those occasions, the medication was documented on the Electronic Medication Administration Record(E-MAR) as being effective
- On 2 occasions, the medication was documented as ineffective
and
- One time, the effect was coded as unknown.

During an interview, resident #022 shared with the Inspector that there was ongoing pain.

Resident #022 expressed to the Inspector that when the medication was administered, it provided comfort for almost 4 hours and because the medication was ordered every 6 hours, was in "excruciating" pain for the next two hours.

PSW #122 told the Inspector that resident #022 had pain all the time and that the pain impacted the resident's spirit and ability to be independent.
RPN #122 advised the Inspector that registered staff offered the PRN narcotic to the resident and that the resident also requested it.
The RPN described the resident's pain as "chronic."

A review of the resident's clinical record did not reveal that registered staff considered regular scheduling of the narcotic analgesic and reassessment by the physician.

Administrator #124, when advised by the Inspector of the frequency of administration of the PRN narcotic analgesic, agreed that registered staff should have considered regular scheduling of the medication and contacted the physician for reassessment per the home's policy. [s. 8. (1) (a),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 policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's restraint policy was complied with.

Resident #021 was observed with a restraint in place.
The Inspector observed PSW #111 reposition the resident's wheelchair from a tilted position to a non-tilted position.

PSW #111 said that the resident was checked hourly to ensure their safety and repositioned every hour.
PSW #111 further said that the safety checks and repositioning of the resident are documented in the Point of Care (POC) program.

Review of the POC program for resident #021 during a time period, revealed that the hourly safety checks had been documented however, repositioning of the resident had not.

PSW #111 explained their understanding that the documentation application available in

POC was to confirm that both safety checks and repositioning had been completed as required.

A review of the homes policy and procedure RCM 10-08 Restraints last revised October 30, 2015 indicated the following:
Documentation
1. Hourly -Personal support workers (PSWs) will monitor and document each Resident with restraints to ensure that the Resident is safe, comfortable and is properly positioned on the Restraint Application Form or within the POC software.

2. Every two (2) hours at minimum -The Resident in a physical restraint must be: Released and repositioned

Documentation of the above will be completed by the PSW's on the Restraint Application Form or within the POC software.

An interview with RPN/RAI Coordinator #103 revealed that the task application in POC for documenting repositioning of a resident with a restraint, had not been added to the resident's profile and therefore, was not available for the PSW staff to complete.
MRC #105 said to the Inspector that it is the home's expectation that nursing staff document on the appropriate application, both safety checks and repositioning of residents with restraints. [s. 29. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care included an order by the physician or the registered nurse in the extended class.

Resident #021 was observed with two restraints in place.
RPN #107 and PSW #111 shared that this was a restraint and that the resident was not capable of removing the device and getting themselves out of the wheelchair.

Review of the resident's clinical record revealed a physician's order was received for one restraint only.
The MRC staff #105 told the Inspector that both devices were being used as restraints and that it was the home's expectation that there would be a physician's order for both. [s. 31. (2) 4.]

2. The licensee has failed to ensure that restraint plan of care include the consent by the resident or if the resident is incapable, by the SDM.

Resident #021 was observed July 20 and July 21, 2016 with two restraints in place.
RPN #107 and PSW #111 shared that the resident had two restraints in place and the resident was not capable of releasing either restraint.

Review of the resident's clinical record revealed a written consent from the SDM for the use of the one restraint, however there was not a consent for the use of the second identified restraint.

RPN staff #107 stated that the resident's clinical record did not include consent from the SDM for the second identified restraint.
The MRC staff #105 shared that the SDM should have signed a consent for the use of the second identified restraint. [s. 31. (2) 5.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols developed, were implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Critical Incident 2898-000010-16 was submitted to the Ministry of Health and Long Term Care April 14, 2016, related to a mandatory report for missing narcotics.
A Registered Team Member(RTM) was administering a narcotic when it was noted that the blister pack card containing the medication was missing.

A review of the critical incident report, the investigative notes, and interviews with staff revealed that staff in the home did not follow the home's policy RCM 09-18 Medication - Storage, Narcotics and Controlled Substances last revised May 12, 2015.

The policy states that:
4. Narcotic counts will be completed at the end of each shift by the outgoing and oncoming Registered Team Member(RTM) responsible for the narcotic supply.
5. Both RTM's must complete a shoulder to shoulder shift count observing the remaining number of controlled medications which will be documented accordingly on the narcotic shift count record.

The home completed an investigation and police were notified however the missing narcotic was not found.

During an interview the Administrator #124 said that it was the home's expectation that Registered Team Members follow the College of Nursing standards of practice and the homes policy and procedure related to narcotic counts. [s. 114. (3) (a)]

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Issued on this 23rd day of August, 2016

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

Original report signed by the inspector.