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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 14, 2014	2014_254515_0004	L-000170-14	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

HILLSIDE MANOR
R. R. #5, STRATFORD, ON, N5A-6S6

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

RAE MARTIN (515), CAROLE ALEXANDER (112), SALLY ASHBY (520)

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): February 18, 19, 20, 21, 24, 25, 26, 27, 2014.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Nutrition Manager, Environmental Manager, Recreation Manager, Assistant Director of Care, Nurse Manager/Resident Assessment Instrument (RAI) Coordinator, Ward Clerk/Scheduler, Registered Nurse (RN), 4 Registered Practical Nurses (RPN), 9 Personal Support Workers (PSW)/Health Care Aides (HCA)/ Nurse's Aides (NA), Maintenance Worker, 40+ Residents and 4 family members.

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

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

In six identified resident rooms, the following was observed:
a) Inside of bathroom door is chipped and in disrepair.
b) Bathroom ceiling tiles have water stains.
c) Inside of bathroom door is chipped and bathroom ceiling tiles have water stains.
d) Wall is worn and in need of paint/upkeep.
e) Bedroom wall radiator in need of paint/upkeep and bathroom ceiling tiles have water stains.
f) Flooring around the toilet and ceiling tiles in bathroom have water stains.

This was confirmed by the Environmental Manager. [s. 15. (2) (c)]

2. The communication and response system was tested in an identified shared resident room. When each of the 4 call bells were activated, they did not cancel.

A Registered and Non-Registered staff members and the Environmental Manager confirmed the communication and response system did not cancel as it is intended to do because it was in disrepair. [s. 15. (2) (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 home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated related to abuse of a resident by anyone as evidenced by:

During an interview with Resident #600, it was revealed that the identified resident had been treated roughly by staff.

Documentation in the resident's clinical record described the incident and indicated the Director of Care would follow up with the resident.

There are no investigation notes for the incident and the Director of Care verified she did not document any information and has no substantiating information.

The Administrator verified the expectation of the home is to do an investigation and to document the findings of the investigation. She confirmed that this had not been done. [s. 23. (1) (a)]

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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated related to abuse of a resident by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of maintenance services there are schedules and procedures in place for routine, preventative and remedial maintenance as evidenced by:

The maintenance program does not include a schedule and/or procedure for preventative maintenance relating to condition and repair of resident bedroom, bathroom areas, resident-staff communication and response system and resident electrical equipment.

This was confirmed by the Environmental Manager. [s. 90. (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 as part of the organized program of maintenance services there are schedules and procedures in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

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. (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 failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices as evidenced by:

There was no evaluation information available for the Infection Control Program for 2013.

This was confirmed by the Director of Care. [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participate in the implementation of the program as evidenced by:

On two consecutive days, call bell cords were observed laying on the floor in three identified resident rooms.

The Assistant Director of Care confirmed the call bell cords should be fastened to the bedding and call bells laying on the floor is an infection control risk. [s. 229. (4)]

3. The following infection control risks were observed on two days in five identified resident rooms:
a) unlabelled personal care items
b) urinal and urinary graduate cylinder observed on the back of the toilet tank in a shared bathroom
c) feces/urine on toilet sink, urine stain on floor, toilet brush on the floor beside toilet. [s. 229. (4)]

4. During medication administration, a Registered Nursing staff member was observed not washing hands/using hand hygiene between residents. Additionally, the nurse failed to sterilize the insulin pen tip before application of the needle between residents.

The Director of Care acknowledged that the Registered staff member had not followed the home's expectations in relation to hand washing. [s. 229. (4)]

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 infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices. Additionally, the plan should include that education is provided to staff to ensure that they are aware of expectations in the program including labelling and proper storage of personal care items as well as hand hygiene/hand washing., to be implemented voluntarily.

WN #5: 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 failed to ensure that there are clear directions to staff and others who provide direct care to the resident as evidenced by:

A documented intervention in the Care Plan for Resident #561 states to ensure eyeglasses are on the resident, are clean and free from scratches and in good repair.

Three Resident Minimum Data Set (MDS) assessments document the resident has no glasses.

The resident confirmed that glasses were previously used for reading and are no longer worn.

Staff confirmed that the resident hasn't worn glasses for a long time, and a Registered staff member confirmed the plan of care does not provide clear direction. [s. 6. (1) (c)]

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

a) Resident #561 was observed sleeping in a wheelchair beside the bed and the call bell was not within reach of the resident.

Documentation in the Care Plan states the resident is a high/medium risk for falls and an intervention is to ensure the call bell is within reach.

The task kardex documents the call bell is to be within reach.

The Director of Care confirmed the expectation that staff are to follow the plan of care.

b) Resident #529 and #531 were both observed sitting in their wheelchairs beside their beds in their rooms. Both call bells were placed on the bed and not within reach of the residents.

Documentation in the Care Plans states the residents are both at high risk for falls and interventions were to ensure the call bells were within reach.

The Director of Care confirmed the expectation that staff follow the plan of care. [s. 6. (7)]

WN #6: 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 a procedure is complied with as evidenced by:

Classic Care Pharmacy 5.8.1 Policy dated October 2010 procedure states:
Each of the two registered personnel sign and date the form in the spaces provided.

On four days, the Narcotic & Controlled Drug Count Sheet is missing the second staff signature for four identified residents.

Interview with the Director of Care verified the missing signatures and stated the expectation is staff would comply with the procedure. [s. 8. (1)]

WN #7: 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, s. 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, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 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, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident that resulted in harm or risk of harm to the resident was immediately reported to the Director as evidenced by:

The Director of Care confirmed there was no report submitted to the Director for an identified incident.

The Executive Director confirmed the expectation is that all matters regarding suspicion of abuse are reported to the Director. [s. 24. (1)]

WN #8: 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 failed to ensure that drugs are stored in an area or a medication cart that is secure and locked as evidenced by:

A medication cart was observed to be unlocked and unattended in an identified home area, accessible to residents.

The Registered staff member confirmed the cart should have been locked and not left unattended. [s. 129. (1) (a) (ii)]

Issued on this 27th day of March, 2014

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

RAE MARTIN