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
Jun 26, 2015	2015_256517_0016	008694-15	Resident Quality Inspection

Licensee/Titulaire de permis

MEADOW PARK (CHATHAM) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK NURSING HOME (CHATHAM)
110 Sandy Street CHATHAM ON N7L 4X3

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

PATRICIA VENTURA (517), RHONDA KUKOLY (213), 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): May 25, 2015 to June 2, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Co-Director of Care, the Education Coordinator, the Food Service Manager, the Registered Dietitian, two Activation Directors, the Building Services Manager, the president of Resident Council, the president of Family Council, four Registered Nurses, three Registered Practical Nurses, four Health Care Aides, seven Personal Support Workers, Residents and Resident Family Members. The inspectors reviewed Resident Health Records, the home's policies and procedures for Skin and Wound, Nutrition and Hydration, Restraints, Abuse and Neglect, Reporting and Complaints, Medications, infection control, Recreation and Social Activities, Continence Care, Maintenance, Laundry Services and Bed Safety. During this Resident Quality Inspection the inspectors observed resident to resident and resident to staff interaction throughout the home.

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

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

6 WN(s)
4 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 the staff and others involved in the different aspects of care collaborate with each other in the assessment of the Resident so that their assessments are integrated, consistent with and complement each other.

The LTCH's policy titled "Resident Rights, Care and Services – Nutritional Care and Hydration Programs – Charting MDS – Nutritional Risk Assessment" indicated the following under procedure:

The Food Service Manager and Registered Dietitian will complete among other things:

A Nutrition Risk Assessment on all Residents quarterly, annually, re-admit from Hospital and if there is a triggered change in condition.

A review of a Resident's progress notes indicated this Resident had a change in condition.

The Administrator confirmed this Resident was not re-assessed by the Food Service Manager or Registered Dietitian related to the change in condition and there was no collaboration with the Dietitian in the assessment of the Resident. [s. 6. (4) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the Resident as specified in the plan.

Health record review for a Resident revealed the Resident presently used a medical device. The Resident received a Physician order for this medical device that directed the Staff to change it every four weeks and as needed.

Further health record review for this Resident revealed the medical device was not assessed or changed for a two month period and there was no planned date to change this medical device.

Interviews with Registered Staff revealed the medical device for this Resident should have been changed as per the Physician order every four weeks and as needed and it wasn't changed for a two month period. The Registered Staff also verified there was no planned date to change it. The Administrator confirmed the care set out in the plan of care for this Resident should have been provided to the Resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the Resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that any actions taken with respect to a Resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

1) Health record review and Staff interviews revealed that a Resident received a Physician order for treatment of an area of altered skin integrity. Treatment Administration Records (TAR)for this Resident indicated the treatment was completed for a period of time. There were no weekly skin assessments documented for this area of altered skin integrity during the same period.

2) Health record reviews and Staff interviews revealed that a Resident received a Physician order for treatment to several areas of altered skin integrity. This Resident's TAR indicated the Resident received the treatment as prescribed for a period of time. There were no weekly skin assessments documented for this area of altered skin integrity for the same period.

3) A review of a Resident's Admission Assessment indicated this Resident had an area of altered skin integrity. Review of this Resident's TAR revealed this area received

treatment for a period of time. There were no weekly assessments documented for this area of altered skin integrity for the same period.

4) A review of a Resident's progress notes indicated to cleanse and monitor an area of altered skin integrity. Review of this Resident's TAR revealed the Resident received treatment to this area of altered skin integrity for a period of time. There were no weekly assessments documented for this area of altered skin integrity for the same period.

5) A review of a Resident's TAR indicated this Resident had an area of altered skin integrity. The Resident received treatment to this area of altered skin integrity for a period of time. There were no weekly skin assessments documented for this area of altered skin integrity for the same period.

6) Progress notes indicated a Resident received treatment to an area of altered skin integrity. Another progress note indicated the resident received treatment to this area of altered skin integrity for a period of time. There were no weekly skin assessments documented for this area of altered skin integrity during this period.

The home's policy titled: "Skin and Wound Care Program" effective September 16, 2013 indicated: "A resident with actual alteration in skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds;
- Has a completed wound progress note, weekly, if altered skin integrity is a wound. This will reflect the weekly assessment of the resident related to wound status."

The Staff Educator confirmed weekly skin and wound assessments were to be documented in the Residents' electronic health record as a "Skin and Wound Note" which was used as the LTCH's clinically appropriate tool for skin and wound care assessments. The Staff Educator confirmed these Residents did not have documented weekly skin and wound assessments using the home's clinically appropriate skin and wound assessment tool for the identified dates.

The Director of Care confirmed that any actions taken with respect to a Resident under a program, including assessments, reassessments, interventions and the Resident's responses to interventions should be documented and in the resident health record. [s. 30. (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 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, 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 the Resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a Registered Dietitian who is a member of the staff of the home.

A review of a Resident's Admission Assessment indicated this Resident had an area of impaired skin integrity. Per this Resident's Treatment Administration Record (TAR), this area required treatment for a period of time.

A review of the Resident's progress notes indicated to administer treatment to this area of altered skin integrity.

A review of the same Resident's TAR indicated this Resident had a second area of altered skin integrity that received treatment during a period of time.

Progress notes indicated this Resident had a third area of altered skin integrity that received treatment during a period of time.

A health record review was completed for this Resident and the inspector was unable to locate any Registered Dietitian assessments for this Resident for the identified areas of altered skin integrity.

A Registered Practical Nurse confirmed Resident #24 was not assessed by the LTCH's Registered Dietitian for the identified areas of altered skin integrity. The Director of Care further confirmed the expectation that any Resident exhibiting alteration in skin integrity be assessed by the LTCH's Registered Dietitian and that this Resident was not assessed. [s. 50. (2) (b) (iii)]

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 Resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a Registered Dietitian who is a member of the staff of the home, 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. (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 Staff participated in the implementation of the infection prevention and control program.

Observations by an Inspector revealed an open tube of Critic Aid, an unlabeled open jar of Infa-zinc cream and a pair of unlabeled nail clippers in a Tub/Shower room.

Observations by an Inspector revealed a used unlabeled Bluewear bed pan on the counter sink beside a labeled denture cup holding a labeled tooth brush and a used, soiled, unlabeled Bluewear K basin on top of the toilet tank in a four bed ward with a shared bathroom.

Staff interviews with the Director of Care and the Administrator and the Infection Prevention and Control Nurse confirmed that the home's expectation for Bluewear was that it was cleaned after use and not stored in Resident bathrooms. The Managers also verified that zinc and Critic Aid should be covered and labeled for each individual Resident and kept in their room, not in the tub rooms. [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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

On a given day, an inspector could hear a Resident verbally calling out. The Inspector went into the Resident's bedroom and noted this Resident had their call bell within reach but when the call bell cord was pulled, the bell did not sound or light up. The Inspector manually activated the switch at the outlet.

A Personal Support Worker confirmed the call bell would not activate when the cord was pulled by the Resident. The Administrator confirmed the expectation was that the Resident-staff communication and response system be on at all times for all Residents at the home. [s. 17. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. 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.

Observation of a medication cart revealed a number of different packages of Nitrodur were noted in individual Resident caddies in the medication cart having been removed from the original package provided by the pharmacy service.

Record review of the Classic Care pharmacy policy binder last reviewed November 2014 revealed:
- Policy 4.2 Administering Routine Medications indicated "Medications should remain in the original labeled pharmacy packaging until just before administration to a Resident"
- Policy 4.8 Safe Storage of Medications indicated "All medications should remain in their original Classic Care Pharmacy or Government Pharmacy labeled container or package until they are administered to a Resident or destroyed".

Interview with the Registered Nurse and the Administrator confirmed that the patches had been removed from their original packaging as they were unaware of this requirement and that staff would not be able to check the Resident name with the medication without the Resident name on the medication. [s. 126.]

Issued on this 2nd day of July, 2015

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

Original report signed by the inspector.