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
Feb 13, 2013	2013_027192_0002	H-001575-12	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

THE MEADOWS
12 TRANQUILITY AVENUE, ANCASTER, ON, L9G-5C2

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 7 , 11, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Recreation Manager, and residents.

During the course of the inspection, the inspector(s) toured the home area, observed the provision of care, reviewed medical records, policy and procedure and reports.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Continence Care and Bowel Management

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours and that minimize the risk of altercations and potentially harmful interactions between and among residents. [r. 55. (a)]

Resident 001 is identified through record review and staff interview to demonstrate verbal and physical aggression. On specified dates in 2013 the progress notes indicate the resident was physically aggressive with staff, verbally abusive toward co-residents, and became agitated and began wheeling themself into people in the dining room.

The plan of care does not address the resident's verbal and physical aggression. Interventions have not been developed and implemented to assist residents and staff at risk of harmful interactions with resident 001. [s. 55. (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 ensuring that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Resident 001 is observed to wear an incontinence product and has a medical device in place. Interview and record review confirm that the resident requests assistance with elimination. Staff interview with Personal Support Workers (PSW) and a Registered Practical Nurse (RPN) indicates that the resident is assisted as requested. The plan of care revised and printed in 2013 indicates that the resident requires two staff physical assistance using a mechanical lift to transfer the resident to facilitate elimination. That the resident is not to be toileted as they are unsafe on the toilet or commode due to physical condition. Under bowel and bladder, the plan of care indicates that the resident is to use an incontinence product, staff are to record elimination and check for wetness on rounds during the night and that the resident has a medical device in place.

The plan of care does not provide clear direction to staff and others related to care required around safe toileting and continence for resident 001. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Resident 001 has a specified care provider. Interview with the RPN, PSW's and the care provider confirmed that the care provider is not kept aware of the contents of the plan of care and does not have convenient and immediate access to it, although they routinely assist with activities of daily living for resident 001. [s. 6. (8)]

3. The licensee failed to ensure the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident care needs change or care set out in the plan is no longer necessary.

Resident 001 sustained a change in condition in 2012, demonstrated by an increase in behaviours described throughout the progress notes. In 2013 the resident became verbally and physically aggressive toward staff and drove their wheelchair into co-residents.

The residents plan of care fails to identify the specified behavious identified in a

documentation review and through interview with Personal Support Workers (PSW), or interventions related to the identified behaviours.

A review of the progress notes for resident 001 identifies that in 2013 the resident made repeated attempts to climb out of bed. The resident is identified in the plan of care to be at risk of falls, however it does not identify that the resident attempts to climb out of bed or interventions already in place to protect the resident from falls. Record review, staff interview and observation confirm the use of specified interventions. In 2013 the resident sustained a fall from bed resulting in injury. [s. 6. (10) (b)]

4. The licensee failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Resident 001 demonstrates responsive behaviours in 2012 and 2013. The plan of care was reviewed and revised in December 2012 and in February 2013 however the revision did not include different approaches related to responsive behaviours identified. [s. 6. (11) (b)]

WN #3: 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 kept clean and sanitary.

Resident 001 was observed to be seated in a wheelchair. In 2013 the wheelchair was observed to be heavily soiled with spilled, dried food/medication over one side of the chair. Dried and hard soiling was noted on the supports of the chair, cushion, and brake. Staff interviewed identified that wheelchairs are cleaned by the night staff. Staff were unable to provide a record of cleaning completed in February. Management was able to locate a record of cleaning indicating that the chair had been cleaned 3 days earlier. The Director of Care indicated that the cleaning of chairs is to be completed weekly and as necessary.

Resident 001's wheelchair was not kept clean and sanitary. [s. 15. (2) (a)]

2. In 2013 resident 002 was observed sitting in a wheelchair. The wheelchair frame was observed to be soiled with a thick layer of dust in spite of recorded weekly cleaning of the wheelchair. [s. 15. (2) (a)]

Issued on this 13th day of February, 2013

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

Debora Saville