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
Nov 16, 2016	2016_448155_0018	031077-16	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF GREY
959 9th Avenue East OWEN SOUND ON N4K 3E3

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

ROCKWOOD TERRACE HOME FOR THE AGED
575 SADDLER STREET EAST P. O. BOX 660 DURHAM ON N0G 1R0

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

SHARON PERRY (155), DOROTHY GINTHER (568), REBECCA DEWITTE (521)

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): November 3, 4, 7, 8, and 9, 2016.

The following intake was completed within the Resident Quality Inspection (RQI): 023765-16 follow up to inspection number 2016_260521_0026 compliance order #001.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Personal Support Worker Coordinator, RAI Coordinator, Food Services Manager, Resident and Family Services Coordinator, Office Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Resident Council representative, Family Council representative, residents and families.

The inspectors also toured the home, reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, positing of required information; observed medication administration, medication storage, the provision of resident care, staff-resident interactions, and the general cleanliness of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2016_260521_0026	521

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. (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).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure the care set out in the plan of care was provided to the resident as specified in the plan.

A record review of progress notes, flow sheets, clinical alerts and the Medication/Treatment Administration Record, revealed resident #041 had a specific device in place that was not functioning properly.

An interview with the Personal Support Worker Coordinator #102 revealed that when the device was not functioning properly it should have been corrected or changed. They also shared that if the device continued to not function properly the resident should have been sent to the hospital or the physician should have been notified.

A review of resident #041's plan of care, revealed specific orders related to the device.

An interview with Registered Practical Nurse #110 revealed the device was changed but there was no documented outcome.

A review of progress notes revealed the device continued to not function properly after it was changed. A further review revealed the residents' device was not corrected, resident #041 was not sent to the hospital, and specific orders related to the device were not followed.

During an interview, with the Director of Care #102, they shared that the care set out in the plan of care should of been provided to the resident as specified in the plan. [s. 6. (7)]

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

During observations, it was noted that resident #018 had bed rails up on their bed.

During an interview with Personal Support Worker (PSW) #114 they shared that resident #018 did not use their bed rails to move in bed.

Review of resident #018's plan of care identified under "Bed Mobility" that the resident used both bed rails to move in bed by themselves during day and evening shift.

During an interview with the Director of Care (DOC) #101, they stated that resident #018 would not be able to use their bed rails to mobilize in bed. The DOC #101 acknowledged that resident #018's care plan had not been revised when the resident's care needs had changed and care set out in the plan was no longer necessary. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan; to 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, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The most recent Minimum Data Set (MDS) assessment for resident #005, identified that the resident, who was at high risk for skin breakdown, had areas of altered skin integrity. The assessment and related Resident Assessment Protocol (RAP) did not identify the location of the areas of altered skin integrity. During a review of resident #005's clinical record, there was no information which identified the location of altered skin integrity and no documentation of an assessment.

During an interview with the Director of Care #101, they indicated that when a Personal Support Worker identified an area of altered skin integrity they were to send an alert on their electronic documentation system at the same time as they commence pressure relieving interventions. This alert went to the registered staff who was then to complete an assessment of the area of altered skin integrity. The assessment would be documented in the progress notes. The Director of Care #101 acknowledged that there were no assessments conducted for the areas of altered skin integrity identified for resident #005.

The licensee failed to ensure that resident #005, who was identified as having altered skin integrity, received an assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #018 was identified on their Minimum Data Set (MDS) assessment, as having areas of altered skin integrity. Record review revealed that resident #018 had altered skin integrity. Record review revealed, registered staff signed the Treatment Administration Record that they had assessed an area of altered skin integrity on three identified days however there was no Skin/Wound Care Assessment completed on the three identified days.

Record review revealed that on four identified days, registered staff signed the Treatment Administration Records that they assessed another identified area of altered skin integrity for resident #018.

An interview done with RN #105, they shared that when there was an area of altered skin integrity, weekly wound assessments were done using the Skin/Wound Care Assessment note in Point Click Care.

An interview done with the Director of Care # 101, they shared that resident #018 did not have a Skin/Wound Care Assessment completed weekly for their areas of altered skin integrity and it was their expectation that a Skin/Wound Care Assessment note in Point Click Care should have been completed weekly for each area of altered skin integrity. [s. 50. (2) (b) (iv)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review revealed that resident #007 was coded on their Minimum Data Set (MDS) assessment as having areas of altered skin integrity. Review of the Head to Toe Assessment done for resident #007, revealed that resident #007 had areas of altered

skin integrity.

Record review done for an identified period of time, revealed that registered staff had been completing weekly Skin/Wound Assessments for some of the areas of altered skin integrity but not for other identified areas of altered skin integrity. There were no reassessments done weekly of some of the identified areas of altered skin integrity.

During interviews with Registered Nurse #104 and #105 they shared that resident #007 currently had altered skin integrity.

Interview done with the Director of Care #102 revealed that there were no reassessments done of some of the identified areas of altered skin integrity. The Director of Care #102 shared that their expectation was that a Skin/Wound Assessment was to be done for each area of altered skin integrity by a member of the registered staff weekly until the altered skin integrity was resolved. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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, and is reassessed at least weekly by a member of the registered nursing staff, in clinically indicated, to be implemented voluntarily.

WN #3: 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 was complied with.

A policy review of policy Catheter Care - Indwelling, Condom and Suprapubic, VII-D-10.30, revealed "Note: Suprapubic catheter re-insertion may be done by a registered nurse (RN) when delegated by the physician / registered nurse extended class (RN EC) and following education by the Physician / RN (EC) or CCAC Community Nursing Agency to the RN in the home".

Record review revealed that Registered Practical Nurses were removing and re-inserting suprapubic catheters.

During an interview with the DOC #102, they shared the policy was not accurate as the Registered Practical Nurses removed and re-inserted suprapubic catheters. The DOC #102 stated that the policy needed to be updated to reflect the current practice in the home as the current policy was not complied with. [s. 8. (1) (b)]

WN #4: 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 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.

A record review of the resident #041's Medication Administration Record / Treatment Administration Record (MAR/TAR), revealed resident #041 had a treatment done. There was no documentation of the resident's responses or reassessment of the resident following the treatment.

An interview with the RPN #110 on November 8, 2016 revealed they failed to document the treatment, how the treatment was tolerated by the resident and the outcome of the treatment. The interview revealed the follow up documentation should have been included in the three shifts post treatment and was not.

An interview with the Personal Support Worker Coordinator#103 revealed it was the expectation that the nurses were to document interventions and the resident's responses to the interventions.

An interview with the Director of Care #101 indicated that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, should have been documented. [s. 30. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

During a review of the Residents' Council meeting minutes for the period of November 2015 - October 2016 there was no documentation to indicate that the meal and snack times had been reviewed at any of the Residents Council meetings.

During an interview with the Residents' Council representative, they did not recall that the meal and snack times had been reviewed at one of their meetings over the past year. The Food Services Manager #112, acknowledged that there was no documentation to indicate that the meal and snack times were reviewed by the Residents' Council over the last twelve months. [s. 73. (1) 2.]

Issued on this 16th day of November, 2016

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

Original report signed by the inspector.