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, 2013	2012_104196_0050	S-001347-12	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

ROSEVIEW MANOR
99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2

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

LAUREN TENHUNEN (196)

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): December 20, 21, 2012

Ministry of Health and Long-Term Care (MOHLTC) Log#: S-001347-12

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW)

During the course of the inspection, the inspector(s) conducted a walk through tour of all resident home areas, observed the provision of care and services to residents, reviewed the health care records of several residents

The following Inspection Protocols were used during this inspection:
Falls Prevention

Minimizing of Restraining

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. On December 20, 2012 at 1215hrs, resident #001 was observed sitting up in a wheelchair in the common dining room with a chair alarm in place and a rear closing seat belt insitu. The kardex as found in the flow sheet binder was reviewed and did not refer to the use of a chair alarm. The care plan with a print date of December 3, 2012 was reviewed and did not include reference regarding the use of a chair alarm. The written plan of care, specifically the care plan and the kardex, for resident #001 did not include the intervention of the use of a chair alarm and therefore did not set out clear directions to staff and others who provide care to this resident.

Resident #004 was observed on Dec. 20, 2012 to have a rear closing seat belt in place while sitting in their wheelchair. The kardex with a print date of October 18, 2012 was reviewed and did not include the use of a rear closing seat belt and instead noted the use of "front closing seat belt done up at all times when in wheelchair". What was observed to be in use on resident #004 was not what was included in the plan of care, specifically noted on the kardex, and therefore did not provide clear directions to staff.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The Physician's orders for resident #001 was reviewed and it was noted that there was changes made to this resident's medications on October 24, 2012. On December 20, 2012, an interview was conducted with staff member #104 and it was reported that any changes to a resident's plan of care, for example, medication changes, the notification of the SDM/POA would be documented in the resident's progress notes. The progress notes, dated October 24 through to November 30, 2012 for resident #001 were reviewed and there was no documentation of the SDM/POA being notified of any medication changes implemented on October 24, 2012. The progress notes on Nov. 30, 2012 did contain reference to the SDM/POA not being notified of the medication changes that had been made back on October 24, 2012.

Resident #001 had changes made to their medications on October 24, 2012 and the SDM/POA was not notified of these changes and therefore did not have the opportunity to fully participate in the development of the resident's plan of care.

The licensee failed to ensure that the resident, the resident's substitute decision-

maker, if any, and any other persons designated by the resident or substitute decision -maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

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 that ensures that there is a written plan of care for resident #001 and #004 that sets out clear directions to staff and others who provide direct care to the residents and also ensures the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of resident #001's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On Dec. 21, 2012 at 1300hrs, the Inspector observed a resident care cart in a storage room. The resident care cart was noted to contain two unlabelled, used, hair combs. Staff member #105 reported that they did not know which residents they may belong to.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (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 that ensures that each resident of the home has his or her personal items labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. On December 21, 2012 an interview was conducted with staff member #102 and it was reported that prior to the home implementing the point of care (POC) computer system, the RPN's would document the reassessment of resident restraints on paper. The inspector and staff member #102 reviewed the POC system for record that the RPN's are documenting the every eight hour reassessments for resident #001's rear closing seat belt. It was determined that this task had not been included in the POC system and therefore there was no documentation of the RPN's reassessing the resident's condition and evaluating the effectiveness of the restraining for resident #001. Resident #004 also had a rear closing seat belt as a restraint device and did not have reassessments done by registered staff every eight hours on the POC system. According to staff member #103, registered staff are to document reassessments of restraint use every eight hours on the POC.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

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 that ensures that resident #001 and #004's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances, to be implemented voluntarily.

WN #4: 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. On December 20, 2012 at 0915hrs, the Inspector conducted a walk through of one of the units and observed two storage rooms were not closed nor the doors locked. The resident care carts were located inside the storage rooms and were found to, both, contain prescription topical creams for residents #002 and #003.

2. On Dec. 21, 2012 at 1300hrs, the Inspector observed a storage room door unlocked, inside was a resident care cart which contained prescription topical creams.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. [s. 129. (1) (a) (ii)]

Issued on this 14th day of March, 2013

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

[illegible] #196.