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
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 7, 2015	2015_271532_0031	029508-15	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

STIRLING HEIGHTS
200 STIRLING MacGREGOR DRIVE CAMBRIDGE ON N1S 5B7

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

NUZHAT UDDIN (532), NANCY JOHNSON (538), SHERRI GROULX (519)

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, 5, 6, 9, 10,12, 2015

This Critical Incidents System (CIS) inspection 005252-15 was conducted concurrently with the Resident Quality Inspection (RQI).

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Director of Dietary, Associate Director of Care (ADOC) Manager of Recreation, Maintenance Supervisor, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family and Resident Council Representatives, Residents and Family members.

Inspector also toured the resident home areas and common areas, medication rooms, spa rooms, observed resident care provision, resident/staff interaction, dining services, medication administration, medication storage areas, reviewed relevant residents clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection, and observed general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

5 WN(s)
5 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. (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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Record review revealed that the Director of Care (DOC) observed a Registered Practical Nurse (RPN) providing a treatment to an identified resident and other staff were assisting with the process.

In an interview the DOC reported that the resident was actively resistive to the procedure and she had requested to have the procedure stopped immediately.

The plan of care outlined a specific approach to care for the identified resident.

The RPN acknowledged that they felt that they had to carry out the treatment.

The DOC confirmed that the RPN did not follow the specific approach to care for this resident.

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. [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 was 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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During stage 1 observations of the Resident Quality Inspection (RQI) 16 out of 40 residents or 40 percent were observed to have one or more bed rails in the up position.

In an interview the Environmental Services Manager (ESM) explained that the home had Joerns Company come to do the bed entrapment assessments; however, they did not use the cone and cylinder assessment tool as per best practice guidelines to measure the potential zones of entrapment on all the beds.

The ESM confirmed that the home did not own the cone and cylinder tool and did not follow the best practice guidelines when completing the assessment for potential zones of entrapment on all the beds.

The Executive Director (ED) confirmed that once the tool was received, the bed assessments for potential entrapment were to be retested on every bed in the home.

Review of the Jorens audit for bed rails indicated that 109 out of 110 residents or 99 percent of the residents in the home used either assist, quarter or half rail.

Record review for three of the residents revealed that there was no documented bed rail assessment.

The Director of Care (DOC) reported that the home at the time of the RQI inspection did not have a formalized assessment for bed rails, the assessment was based on the clinical judgment of the registered nursing staff, the physiotherapist and restorative team. It was confirmed with the DOC that there were no documented bed rail assessment at the time of the inspection, however, since the RQI inspection all of the residents in the home were assessed for bed rails. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, steps were steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Review of the Jorens audit for bed rails indicated that there were 15 beds that had failed for bed entrapment.

Upon interview with the Environmental Services Manager (ESM), it was confirmed that Joerns Company came in to do the home's bed assessments. The ESM stated that the assessment had recommended installing corner guards to mitigate the risk but only 30 percent had been installed so far.

Upon interview with the Executive Director (ED) it was stated that the ESM had installed the corner guards on the failed beds noted by Joerns but that of all the beds in the home, only 30 percent had been installed.

The ESM confirmed that they were installing corner guards on all of the beds that failed in zones two and three.

The Executive Director (ED) confirmed that once the corner guards were installed and the tool was received, the bed assessments for potential entrapment were to be retested on every bed. [s. 15. (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 where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident and to ensure that where bed rails were used, steps were steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, 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 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.

Record review revealed an altered skin integrity was noted for an identified resident.

Record review further revealed the same identified resident had another area of altered skin integrity.

Policy called Skin and Wound program, defined Altered Skin Integrity as the "potential or actual disruption of epidermal or dermal tissue. This includes all skin breakdowns, including but not limited to bruises, skin tears, rashes, wound/ulcers, burns and lesions".

Policy further stated under Documentation /Monitoring that the "Treatment Observation Record (TOR)-Initial Wound Assessment is initiated when a resident has any open area/wound one TOR for each open area will be completed, the Treatment Observation Record (TOR)-initial wound Assessment will be printed from PCC and kept in the treatment binder for each individual wound."

Record review revealed that there was no Treatment Observation Record (TOR)-Initial Wound Assessment completed for the altered skin integrity.

In an interview the Associate Director of Care (ADOC) responsible for the Skin and Wound program confirmed that the staff were not completing the TOR-Initial Wound Assessment for all skin breakdowns including skin tears as stated in the policy. [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, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review revealed that an identified resident had altered skin integrity.

Upon review of the assessments, it was noted that there was no mention of altered skin integrity and there were no further progress notes written about the altered skin integrity.

Upon interview with a Registered Practical Nurse (RPN), it was stated a weekly progress note should have been done to assess the altered skin integrity but that was not done. [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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

a) Clinical record review stated that the identified resident was usually continent of bowel, less than weekly.

In an interview the resident stated that they were incontinent of bowel.

b) Clinical record review stated that another identified resident was occasionally incontinent of bowel.

In an interview, the resident stated that they were incontinent of bowel.

Policy called Continence Care stated under assessment that the nurse was to "initiate the 3 day continence assessment on admission and/or if there is a change in level of continence."

The DOC confirmed that the residents who were identified as incontinent of bowel did not receive an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

In an interview with the DOC, it was also identified that the Admission/Quarterly Continence Assessment (ON) that was to be completed by the registered staff did not address the causal factors for bowel, patterns, type of incontinence and potential to restore function with specific interventions, and was not a clinically appropriate assessment instrument in respect to bowel function. [s. 51. (2) (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 the residents who are incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #5: 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 has failed to ensure that drugs were stored in an area or a medication cart, that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting).

During the medication room observation five expired medications were found in one identified medication room and two in another.

Upon interview with a Registered Practical Nurse the expired medications were confirmed on both medication rooms.

The licensee failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting) when expired medications were found in the medication rooms. [s. 129. (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 drugs were stored in an area or a medication cart, that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting), to be implemented voluntarily.

Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.