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
Jun 23, 2016	2016_267528_0012	002236-16	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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

CYNTHIA DITOMASSO (528)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): June 13, 14, 15, 2016

Complaint inspection log #'s 002236-16, 008727-16 were completed as a part of this inspection, related to staffing and accommodation services.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Resident Assessment Instrument (RAI) Coordinator, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff, recreation staff, and residents.

The inspector also observed the provision of care and services and reviewed documents, including but not limited to, complaints log, clinical health records, staffing schedules, bathing schedules, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

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

4 WN(s)
3 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 O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A. The plan of care for resident #081 identified that the resident required assistance with bathing related to impaired cognition and physical limitations. Review of Point of Care (POC) documentation identified that the resident did not receive a scheduled bath on one occasion in March 2016, and one in June 2016, and no make-up bath was provided.

B. The plan of care for resident # 082 identified that the resident required extensive assistance with bathing. Review of POC documentation identified that the resident did not receive a scheduled bath on one occasion in May 2016 and no make up bath was provided. Review of the PSW staffing schedule identified that the home was working short staffed on the evening, when the resident's bath was scheduled.

C. The plan of care for residents #081 and #083 identified that the residents required assistance with bathing. Review of POC documentation identified that the residents did not receive their scheduled baths on one occasion in June 2016 and no make up bath was provided. Review of the staff schedule identified that the home was working short PSW staff on the identified day in June 2016.

Interview with PSW #111 revealed that when the home worked short PSW's, they were not able to complete all scheduled baths; however, they would try to make-up the bath on the following shift. Interview with registered staff #110 confirmed that scheduled baths were not provided to the resident on the dates listed above, and also confirmed that the home was working short staffed on the identified days. Registered staff #110 identified that as of April 2016, when a scheduled bath was missed an action plan was created for each resident to ensure that the bath would be made up; however, had not been completed for the missed baths identified above. [s. 33. (1)]

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan:
(a) provided for a staffing mix that was consistent with residents' assessed care and safety needs
(b) set out the organization and scheduling of staff shifts
(c) promoted continuity of care by minimizing the number of different staff members who

provided nursing and personal support services to each resident

A. During the Resident Quality Inspection in February 2016, a voluntary plan of correction was issued related to the home's staffing plan. Anonymous concerns of staffing were submitted to the Ministry of Health and Long Term Care In January and March 2016, identifying ongoing staffing concerns.

B . On June 14, 2016, from approximately 0700 hours, the provision of care and services was observed. At 0705, resident #080 was observed sitting at the side of the bed with no pants on, they had removed their brief, which was placed on the floor. The resident indicated they had been told by staff that they would be back soon to help them with morning care. At 0720, the resident remained seated at the side of the bed waiting for staff. Interview with the resident identified that they often had to wait a long time for help in the morning. At 0740, PSW staff entered the resident's room and stated that they would be back in two minutes to help the resident. The resident was overheard telling staff about their frustration with the wait. The PSW, who was on an orientation shift, apologized and informed the PSW staff, that resident #080 required assistance. Interview with registered staff #109 confirmed that there had been a sick call that morning and therefore, the home was working one PSW short since 0600 hours. A replacement had been called for 0800 hours.

C. From 0925 to 1005 hours, resident #086 rang their call bell four times, requesting to go back to bed. On the fourth ring two PSWs assisted the resident to bed using a mechanical lift. Interview with PSW #101 confirmed that the resident requested to go back to bed immediately after breakfast, but staff were unable to complete the two person transfer until all residents were out of the dining room. Interview with resident #086 confirmed that they had been up before 0700 hours and had to wait too long for assistance back to bed.

D. Review of Point of Care (POC) documentation of bathing schedules, identified that when the home was working short PSW's, bathing was not completed and not made up on an identified weekend in June 2016, for residents #081 #083 and #084. Furthermore, resident #081 did not receive a scheduled bath on one occasion in March 2016, due to the home working short a PSW on both day and evening shifts; and resident #082 did not receive a scheduled bath on one occasion in May 2016, due to the home working short a PSW on evening shift. Interview with registered staff #110 confirmed the home worked short and baths were not made up for residents on the dates listed.

E. On June 15, 2016, from approximately 0630 hours, the provision of care was observed. The home was fully staffed and PSW #102 was on their last orientation shift. PSW #102 was observed providing morning care to approximately five residents and assisted with five lifts. Interview with PSW #103 and 105, confirmed that PSW #102 was not part of the regularly scheduled staffing schedule, and was an extra PSW on the floor. Interview with PSW #102 confirmed that they provided morning care to a number of residents and was a second PSW for two person lifts and transfers for several residents, getting out of bed and in the spa room. The last resident to enter the dining room was at 0835 hours, with one extra body on the floor assisting with resident care.

F. Review of the home's staffing schedule from March 2016, identified that in March the home worked short PSWs approximately forty five hours on day shift and forty three hours on evening shift. In May 2016, the home worked short forty eight hours on day shift and twenty four hours on evenings. Interview with the ED and DOC identified that the home continued to develop the staffing plan by reorganizing bathing schedules, adjusting PSW shift start and end times, and increasing the staffing pool by recruiting staff. A total of seven registered staff members and five PSW staff have been hired in 2016. [s. 31. (3)]

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 staffing plan:
(a) provides for a staffing mix that is consistent with residents' assessed care and safety needs
(b) set out the organization and scheduling of staff shifts
(c) promotes continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work? (including 24/7 RN coverage), to be implemented voluntarily.

WN #3: 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 all staff participated in the implementation of the infection prevention and control program.

A. The homes policy "Hand Hygiene, HS17-O-11", last revised January 2015, identified that staff were to complete hand hygiene, not limited but including the following: before and after contact with residents that pose infection risk, immediately after removing gloves at the end of a task, after handling or touching potentially contaminated items or surfaces, after personal hygiene.

On June 14, 2016, PSW #112 was observed exiting a resident's room wearing gloves. The PSW removed their gloves and then used a general purpose key, available to all staff, to open a locked door and retrieved two briefs. The PSW then returned back to the resident's room. Approximately 15 minutes later, the PSW was seen exiting the residents room holding a bagged brief. The bagged brief was discarded and gloves removed. The PSW then immediately entered a second resident's room. Approximately five minutes later, the same PSW exited wearing gloves with a bagged brief in hand. The bagged brief and gloves were discarded, and the PSW attempted to enter a third resident's room. No hand hygiene was completed at anytime during the observation. Interview with PSW #112 confirmed that morning care was provided to two residents, including but not limited to incontinent care and application of treatment creams. The PSW confirmed that gloves were worn during the care but hand hygiene was not completed after removing the gloves, as required in the home's policy. [s. 229. (4)]

B. Environmental Cleaning for Prevention and Control of Infections In All Health Care Settings - 2nd edition, last revised May 2012 by Provincial Infectious Diseases Advisory Committee (PIDAC) identified that general waste, including but not limited to, incontinent pads and briefs, were to be discarded into black, green, or clear bags at point-of-care and stored in an enclosed room or area.

On June 15, 2016 at approximately 0735 hours, PSW staff #103 and was observed portering resident #085 down the hallway, after morning care. The PSW entered a

second resident room. Approximately ten minutes later, a soiled brief, resident clothing, and a basin full of water, were observed sitting on the floor by the head of the bed of resident #085, in a four bed shared room. PSW staff throughout the course of the inspection, confirmed that briefs were to be discarded into bags and then carried to a large bag in the hallway. Interview with the DOC and ED confirmed that the home instructed staff to bring small bags into residents' rooms before providing incontinent care, so that the soiled brief could be placed in a bag and not on the floor. Observations and an interview with the ED confirmed that the home ensured there were bags available to staff and that placing soiled briefs on the floor was not part of the home's cleaning guidelines to staff. [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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that residents' linens were changed at least once a week and more often as needed.

On an identified morning in June 2016, resident #080 was sitting in bed, a large brown dried stain was observed on the top of the resident's pillowcase. A second pillow did not have a pillowcase covering the pillow. The following morning, the resident was observed laying in bed, resting their head on the brown stained pillowcase, the second pillow remained without a pillowcase. Review of the Bathing Schedule, POC documentation and interview with the resident confirmed that the resident received their scheduled bath on the identified day in June 2016. Interview with registered staff #110, on the second observation day, confirmed the linens were dirty and needed to be changed. Interview with the DOC confirmed that staff were to change linen's on the residents' scheduled bath day, which was not implemented on the identified day in June 2016, for resident #080. The DOC also identified that they were unable to locate a written procedure related to the changing of residents' linens. [s. 89. (1) (a) (i)]

Issued on this 25th day of July, 2016

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

Original report signed by the inspector.