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

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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
Oct 11, 2013	2013_198117_0020	O-000873-13	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

HEARTWOOD
201-11TH STREET EAST, CORNWALL, ON, K6H-2Y6

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

LYNE DUCHESNE (117)

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): September 24, 25 and 26

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Clinical Care Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the Registered Dietitian, a dietary aide, a physiotherapy aide, family members and to several residents.

During the course of the inspection, the inspector(s) reviewed an identified resident's health care record; observed an identified resident's provision of care and services; observed the lunch time meal service of September 25 and the breakfast meal service of September 26, 2013; observed food and beverage snack pass of September 24 and 25, 2013; reviewed the home's policy Revera Skin and Wound Care Program-National Policy #LTC-N-20, revised March 2012, Treatment and Observation Record: Wound/Skin Assessment #LTC-N-20-30, Procedure Guidelines for Management of the Resident with an Indwelling Catheter, and Closed Drainage System and Guidelines for Emptying and Storage of Urinary Drainage Bags, revised March 2006.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Hospitalization and Death

Infection Prevention and Control

Medication

Nutrition and Hydration

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s 6. (9) (1) in that the provision of care set out in the plan of care related to an indwelling urinary catheter was not documented.

On a specified day in July 2013, Resident #1 returned from hospital. He/she had an indwelling urinary catheter in-situ. Documentation indicates that the indwelling urinary catheter is intact and patent.

Three days later, Resident#1's care plan was updated to reflect that the resident had an indwelling urinary catheter. Two nursing interventions regarding the catheter's care were identified: monitoring for changes in urinary output characteristics and catheter patency. No other information related to catheter care, catheter and drainage bag replacement as well as patency were documented.

Eight weeks later, in September 2013, is the next documentation entry noted in all of the resident's health care record related to the catheter. It is a medical order to discontinue Resident #1's indwelling urinary catheter. Progress notes document that the catheter was discontinued on a specified day in September 2013 and that a urine C&S was done and sent for analysis. The laboratory reports show that Resident #1 had a urinary tract infection. He/She was treated with antibiotics.

The home has a "Procedure Guidelines for the Management of the Resident with an Indwelling Catheter, and Closed Drainage System". The guidelines state " Change catheter according to the needs of the resident. An indwelling catheter should not be changed at arbitrarily fixed intervals. Usually the catheter is not changed except when obstruction or malfunction occurs. Inspect the catheter after removal for evidence of encrustation; if there are no signs of encrustation, and blocking of lumen, the interval between catheter changes may be increased."

Resident#1's medical orders, Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed with staff member S#202 on September 26, 2013. The staff member confirmed that there are no interventions noted on these documents related to the monitoring and changing of the catheter. No notes were found in Resident #1's progress notes, MAR and TAR to indicate that the catheter was monitored and changed between specified dates in July to September 2013.

Interviewed staff members S#207, S#208 and S#209 state that the resident's

indwelling urinary catheter was patent from specified dates in July to September, but were unable to give detailed information about the care provided to the resident in relation to the indwelling urinary catheter. Point of Care electronic documentation system used by the staff members only notes that Resident #1 had an indwelling catheter. No other information regarding provision of care, urine characteristics and catheter patency is noted. [s. 6. (9) 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 all provision of care, including the monitoring and changing of indwelling urinary catheters care is documented in the residents health care records, 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 failed to comply with O/Reg79/10 s .50 (2) (b) (i) in that Resident#1 who has a wound did not receive a skin assessment with a clinically appropriate assessment instrument for wounds and (iv) was not reassessed weekly by a member of the registered nursing staff.

Resident#1 has a wound. The resident is closely followed by medical specialist. Order received from the medical specialist on a specified day in August 2013 for a specific type of wound dressing to promote healing. There was a delay in applying the specialized wound dressing due to the availability of a specific type of wound equipment from the medical supplier.

Progress notes and MAR documentation note the following:

On a specific day in August 2013, specific wound dressing was applied.
4 days later- progress notes state the battery was depleted so it was changed
11 days later- progress notes state the wound dressing in place.
13 days later- progress notes state dressing was changed on a specified date in August 2013.
22 days later- MARS state wound dressing was discontinued as the wound was healed.

There is no other documentation on the nursing progress notes as it relates to the wound status, the functioning of the specific type of wound dressing and the dressing changes and any other provision of care given to the resident as it relates to the specific wound dressing. There is no documentation on the nursing progress notes stating that a reassessment was completed at least weekly by a member of the registered staff using a clinically appropriate assessment instrument for wounds. [s 50 (2) (b) (iv)]

On September 26, 2013, the home's clinical care coordinator informed inspector #117, that the home had not been using a clinically appropriate assessment instrument for skin and wounds when the resident was receiving the specific type of wound dressing. At that time nursing staff were to document in progress notes and MAR/TAR any skin and wound issues. The home's policy was modified in early September 2013 so that nursing staff are now to use the "Treatment and Observation Record From for Wound/Skin Assessment (policy LTC-N-20-30)." This form was not used to assess Resident #1's surgical wound. [s. 50. (2) (b) (i)]

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 clinically appropriate skin and wound assessment tool be used at all times in the home, that registered nursing staff be trained on the use of this clinically appropriate assessment tool, and that residents who have wounds are reassessed weekly using the clinically appropriate assessment tool by a member of the resgistered nursing staff, to be implemented voluntarily.

WN #3: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 51 (2) (b) in that the resident who is incontinent did not have an individualized plan as part of his/her plan of care to promote bowel continence based on the assessment and that the plan is implemented.

Resident #1 has a history of constipation. It is noted that resident is receiving a narcotic medication twice a day plus a narcotic medication as needed (prn) every 4 hours on a regular basis for pain as well as a mineral supplement for a medical condition.

Bowel management interventions for the resident include: 2 laxatives to be given on daily basis as well as on a prn basis. Medical orders are in place for the resident to receive medical interventions as per the home's bowel management protocols. The home's protocol for no bowel movements for 3 days, is as follows:
- day 3 : Senokot tabs 1 or 2 at night
- day 4 : Senokot tabs 1 or 2 at night
- day 5 : Rectal exam for fecal impaction then fleet enema pr on day shift
- day 6 : Rectal exam for fecal impaction then fleet enema pr on day shift

Resident #1 stated to Inspector #117 that he/she is regularly constipated since having multiple medical interventions in 2013, having bowel movements occurring about every 5 days. A review of the resident's health care record shows that between early August to late September 2013, the resident has had several episodes of constipation lasting 3 to 5 days without a bowel movement.

Medication Administration Records (MAR) and progress notes document the following:

- Early August 2013. Resident #1 is 5 days with no bowel movement. Senokot was given on day 5 when protocols indicate that a rectal exam to monitor for fecal impaction and then a fleet enema should be given. No other earlier interventions are noted. No documentation of the effectiveness of administered interventions is noted.

-late August 2013, Resident #1 is 3 days with no bowel movement. The resident complained of nausea on a specified day in August. An anti-nausea medication was administered but effectiveness of the medication was not documented. Two days

later, an anti-nausea medication was given again for nausea. No documentation of its effectiveness is noted. Daily care flow sheets document that 2 days later, the resident had a bowel movement. However, resident became constipated once again presenting with nausea and emesis on a specified day in August. Anti-nausea medication was given twice and the effectiveness of the medications were not documented.

- By a specified day in August, the resident had no bowel movement for 3 consecutive days with no interventions noted to have been implemented as per the resident's bowel management protocol.

- On a specified day in September, documentation shows that the resident had a bowel movement but was subsequently constipated for 5 days. On the 5th day, Resident #1 had nausea with brown "liquidy" emesis. He/She received anti-nausea medication. Bowel sounds were noted present in all quadrants and later had a bowel movement as per documentation. However, no other information was noted related to the effectiveness of the anti-nausea medication, nor to bowel monitoring and management interventions.

Discussion held with staff members S#204 and S#205 on September 25 and 26, 2013. The staff members stated that resident #1 will occasionally refuse prn laxatives and Fleet enemas when he/she is constipated. Refusal of prn bowel management medication was not reported to the RN.

Discussion was held with staff member S#202 on September 26, 2013, regarding the resident's frequent constipation, ongoing need for narcotics and mineral supplements as well as the current bowel management interventions. The staff member stated that he/she is aware that the resident is frequently constipated, up to 5 days with no bowel movements and occasionally presenting with nausea and emesis. To his/her knowledge, the resident's bowel management interventions have not been reassessed and that no concerns were brought to his/her attention by other staff members regarding the resident's constipation issues. Staff member S#202 also confirmed that the home's bowel management protocol was not individualized for Resident #1.

Resident #1's plan of care does not identify that the resident has frequent constipation and there are no resident specific nursing interventions identified for this resident

other than medication interventions noted in the MAR.

Resident #1's dietary needs were reassessed by staff member S#203 on a specified day in August 2013. No identification of constipation issues were noted. Inspector #117 spoke with staff member S#203 on September 25, who confirmed that he/she was not aware of Resident #1's constipation issues. There are no dietary interventions identified in the resident's plan of care related to constipation.

Resident #1's constipation and bowel management needs were not reassessed by nursing and dietary services. Plan of Care interventions are not individualized to promote and manage Resident #1's bowel continence. [s. 51. (2) (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 ensure that the Resident #1 has an individualized bowel management plan of care that addresses constipation, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to comply with OReg 79/10 s.134(a) in that when a resident is taking any drug or combination of drug there was not monitoring or documentation of a residents response and the effectiveness of the drugs.

Resident #1 has orders for regular and prn narcotics for pain control. Resident#1 also has orders for an anxiolytic prn. A review of the resident's health care record shows that several medications where administered to assist with pain and anxiety however the resident's response to these medications and the effectiveness of the medication where not consistently monitored and documented.

Resident #1 is prescribed a narcotic medication twice a day and every 4 hours prn for pain management and an anxiolytic twice a day prn for anxiety.

On a specific day in August 2013- resident requested prn narcotic medication for pain which was given at early on night shift. Chart documentation shows that the resident was reassessed 2 hours later, the resident expressed at that time the need for more medication. No further actions were documented by nursing staff to reassess the resident for further pain management intervention.

On a specific day in August 2013- Resident received narcotic medication for pain early on the night shift. There is no further documentation by nursing staff stating the effectiveness of the prn medication.

On a specific day in August 2013- Resident received a narcotic medication for pain during the day shift. There is no further documentation by nursing staff stating the effectiveness of the prn medication.

On a specifice day in August 2013- Resident was given regular narcotic medication. Progress notes document that the resident received prn narcotic, prn anxiolytic and a regularly prescribed benzodiazepine medication at approximately same time. There is no nursing documentation as to the monitoring of the effective/impact of the two regular medications given at the same time as the two prn medications. [s. 134. (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 registered nursing staff monitor and document the effectiveness of prn narcotics and anxiolytics, to be implemented voluntarily.

Issued on this 24th day of October, 2013

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