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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## 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 |
|---|---|---|---|
| Oct 14, 2015 | 2015_200148_0032 | O-002648-15 | 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

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

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

AMANDA NIXON (148), KATHLEEN SMID (161), MEGAN MACPHAIL (551), MELANIE SARRAZIN (592)

### 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): September 28- October 2, 2015 and October 5-8, 2015.**

**The RQI also included four inspections related to critical incident reports and one inspection related to a complaint.**

**During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Resident Services Coordinator (RSC), Recreation & Restorative Care Manager, Resident Assessment Instrument Coordinator, Dietary Manager, Environmental Services Manager, Registered Dietitian, Payroll/Scheduling, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers (FSW), Housekeeping Aids, Laundry Aids, Residents and Family Members.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Laundry**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

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

**7 WN(s)**
**1 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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 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, if clinically indicated.

On September 29 and October 2, 2015, Resident #23 was observed with two open wounds on the facial area. Both areas were observed to have dried blood along with scabbing. On a date in August 2015, the resident was prescribed a treatment cream which was later discontinued and changed to a different prescribed cream that same month. Treatment administration records (TARs) for August and September indicate the cream was provided up until mid-September 2015 concluding the prescribed treatment.

Staff reported that these are self-inflicted wounds, whereby the resident will scratch and pick causing the openings, a behaviour related to the resident's diagnosis. Staff interviews and the health care record confirm that prescribed treatment creams have

been used effectively to manage the wounds in the past.

Inspector #148 spoke with RPN #110 who indicated that the home has a skin assessment tool in place to assess pressure wounds and skin tears, titled the Initial Wound Assessment. She noted that the wounds present for Resident #23 are recurrent and related to behaviours and the wounds are not seen as skin tears or pressure areas so no assessment tool is used to asses the wounds. The RPN noted, however, that all residents provided a medicated/prescribed cream are assessed weekly to ensure that the creams are still required for the resident, by use of a progress note that is triggered by the electronic TAR. Inspector spoke with the home’s ADOC who confirmed that the wounds identified for Resident #23 required an initial wound assessment using the home's clinically appropriate tool available at onset and weekly assessment thereafter.

The Inspector reviewed the health care record of Resident #23 and spoke with staff, demonstrating that no skin assessment was conducted using a clinically appropriate assessment instrument for Resident #23 who was exhibiting altered skin integrity, that began as early as August 2015. In addition, no weekly assessments had been completed during the time whereby treatment was provided, as indicated by the home’s ADOC and policy #LTC-E90 related to the management of skin lesions.

Further to this, between the time the prescribed cream concluded to the time of the Inspectors review, observations documented by PSWs, indicate that open areas of the skin remained. Interviews with staff indicate the current wounds, as observed by Inspector #161 on September 29 and Inspector #148 on October 2, 2015, are not new wounds. There is no indication that after the prescribed cream had concluded that Resident #23, who was exhibiting altered skin integrity received treatment and interventions to reduce pain, promote healing and prevent infection, as required. [s. 50. (2) (b) (i)]

2. Resident #35 has a history of pressure wounds on coccyx and buttocks attributed to the resident's diagnosis and physical limitations. On a specified date, it was recorded in the progress notes that the resident had no skin breakdown to buttock or coccyx. Nine days later, a progress note indicates that 2 small open areas had appeared. Staff were instructed to continue with cleanser and barrier spray and to monitor the areas.

A review of the health care record including the TARs, progress notes and treatment binder, in addition to interviews with RPN #110 and RPN #104, demonstrated that Resident #35 did not receive an assessment using the home's clinically appropriate

assessment instrument (Initial Wound Assessment). In addition, it was confirmed by both RPNs and the home's ADOC that the resident would have required weekly assessments for the wounds using both progress notes triggered by the TAR and by use of the Wound Assessment- Treatment Observation Record. Thirteen days after the open wounds were observed, the treatment was revised. Progress notes were used by registered nursing staff to track the provision of treatment to the wounds, however, there was no weekly assessment as required. [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 resident exhibiting altered skin integrity receives assessment using a clinically appropriate instrument and is reassessed weekly if clinically indicated, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home**

**Specifically failed to comply with the following:**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,**
**i. kept closed and locked,**
**ii.equipped with a door access control system that is kept on at all times, and**
**iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,**
**A. is connected to the resident-staff communication and response system, or**
**B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.**
**O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**
**3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.**
**4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:**
**2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all doors leading to stairways must be kept closed

and locked, equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be canceled only at the point of activation and is connected to the resident staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Heartwood is a building with three floors, with the upper two floors used primarily for resident bedrooms and living space. The lower level (i.e basement) of the home is accessible to residents from the first floor elevator. Within the basement are activity areas and physiotherapy services along with utility, kitchen and building service areas. During the inspection, the inspection team observed several residents using the basement level of the home to attend activities and wander unattended.

While on tour with the home's Environmental Services Manager, Inspector #148 observed a door in the basement of the home which lead to a long corridor, at the end of which is a stairwell leading to all levels of the home. The door is opened by a push mechanism, the door was not equipped with a lock, a door access control system or door alarm. In addition to leading to a stairwell, the safety risk to residents was escalated as the corridor also leads to the maintenance room, within which is a door leading to the outside that was found to be unlocked, with the magnetic lock system deactivated. [s. 9. (1)]

2. The licensee failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

On September 30, 2015, Inspector #148 observed the electrical room door, located across from the kitchen area in the basement of the home, to be equipped with a lock, however was propped open and unsupervised at the time. The electrical room posed several hazards including a cluttered space with tools and other items on the floor and an open electrical panel. The inspector spoke with two dietary staff who indicated that the room is being used by outside contractors for the purpose of testing alarms in the building. Neither staff member were comfortable to close the door as they were unsure if the contractors had a key to open the door. Inspector #148 approached the home's DOC on the first floor, who indicated the electrical room door needs to be closed and locked and that she would follow up with this.

On October 5, 2015, during a tour with the home's Environmental Service Manager, a

utility door was found unlocked on the first floor, containing oxygen tanks and miscellaneous items and was unsupervised at the time.

Each of the residential floors has a "tic room", used by PSW staff members to complete documentation and store miscellaneous items. On several occasions including October 2 and October 5, 2015, Inspector #148 observed the first floor North tic room, located near the end of the North hallway, to be equipped with a lock but found to be ajar, unlocked and unsupervised. During the observation of October 2, 2015, a PSW staff member was observed to enter the tic room through the unlocked door and leave the area without locking the door behind her. The North tic room on the second floor was also observed on October 5, 2015 by Inspector #161, to be equipped with a lock but unlocked and unsupervised. [s. 9. (1) 2.]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

**Specifically failed to comply with the following:**

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily accessed by Resident #29 at all times.

The home is equipped with a resident-staff communication and response system (call bell) that is activated by pushing a red button at the end of the call bell cord or by pushing a button on the wall panel. The location of an activated call is illuminated on a panel in the hallway and a chime is heard.

Resident #29 likes to spend time in his/her bedroom seated in a recliner chair which is located along the wall, past the foot of the bed. When fully extended, the call bell cord rests on the resident's bed and is not easily accessible when he/she is seated in the chair. The call bell cord is approximately four feet short of being accessible to the resident. The resident stated that he/she would not chance getting out of her chair and walking to over to the bed to activate the call bell.

On a table, next to Resident #29's recliner chair is a hand bell. The resident stated that he/she has been instructed to use this in place of a call bell. Resident #29's room is the last room at the end of the hallway.

The DOC was interviewed and agreed that access to a hand bell versus a call bell connected to the communication system could be a safety hazard for Resident #29. The DOC stated that she would order a longer call bell cord so that Resident #29 could easily access the call bell when seated in the recliner chair in his/her room. [s. 17. (1) (a)]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

**Specifically failed to comply with the following:**

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes an offer of an annual dental assessment subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

On October 5, 2015, a discussion was held with the Administrator who indicated that when a resident is admitted to the home, a document titled "Unfunded Services Agreement" is reviewed with the resident and/or the resident's substitute decision maker. This document includes the option for the provision of initial and annual dental assessments provided that, the resident or resident's substitute decision maker agrees to this service and the associated cost. The Administrator indicated that the home currently does not have a process in place to offer an annual dental assessment, subject to payment, to those residents who initially declined the service on their admission to the home. The Administrator indicated to Inspector #161 that a process would be immediately initiated to rectify this oversight. [s. 34. (1) (c)]

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:**

**1. A change of 5 per cent of body weight, or more, over one month.**
**2. A change of 7.5 per cent of body weight, or more, over three months.**
**3. A change of 10 per cent of body weight, or more, over 6 months.**
**4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a weight change of 5 per cent or more over one month was assessed using an interdisciplinary approach and that actions are taken and outcomes are evaluated.

As of June 2015, Resident #31 was at moderate nutritional risk due to disease process, decreased intake and gradual weight loss. The resident's weight in July 2015, resulted in weight loss of over 5 per cent in one month. A review of progress notes for the month of June 2015 indicated the resident was experiencing responsive behaviours with need for medication adjustment. Progress notes of July 2015 indicated an increase in drowsiness contributing to a decrease in oral intake, with need for medication adjustment as it relates to the resident's diagnosis and behaviours. Although oral intake was followed by nursing staff throughout the month of July 2015, there was no indication of an assessment of the weight loss.

Inspector #148 spoke with the home's NM and reviewed documented communications between the NM and RD. The NM completed a referral to the home's RD on a specified date in early July 2015, related to the decreased intake. The home's RD assessed the weight loss and intake on a specified date in mid-September 2015.

Resident #31's weight loss indicated by the weight measure of July 2015 was not assessed until September 2015. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

**WN #6: 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 are stored in an area that is used exclusively for drugs and complies with manufacturer's instructions for the storage of drugs.

On October 2, 2015, while reviewing the home's skin and wound program, Inspector #148 observed medicated creams stored in the unlocked North hallway "tic room". During a tour on October 5, Inspector #161 in the company of the home's ADOC, observed that medicated creams for residents were stored in areas that were not used exclusively for drugs. The first and second floor linen rooms as well as the tic room located in the North hallway, contained multiple prescribed creams for 35 residents along with hair supplies, resident equipment and linens. It was also observed by both Inspector #161 and the ADOC that four medicated creams had expired with dates ranging from December 2014 to May 2015. The ADOC agreed that these medicated creams needed to be stored in an area that is used exclusively for drugs and that a process is required to identify and remove expired prescribed creams. [s. 129. (1) (a)]

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

**Specifically failed to comply with the following:**

**s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,**
**(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).**
**(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).**
**(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a member of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

On October 8, 2015, the RSC #102, who is a registered nursing staff member, indicated to Inspectors #592 and #161 that she usually trains the Personal Support Workers (PSW) on an annual basis in the administration of topicals. She also indicated that in May 2015 she asked PSW #127 who was on modified duties, to train the PSWs in the administration of topicals. A review of the 2015 in-service records provided by the RSC indicated that on May 30 and 31, 2015, PSW #127 trained a total of 16 other PSW's in the administration of topicals. Discussion held with RSC, who indicated that she was unaware that PSW's had to be trained by a registered nursing staff, not by a PSW, in the administration of topicals to residents; and that the 16 PSWs would be retrained by the end of the month. [s. 131. (4)]

**Issued on this 14th day of October, 2015**

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

**Original report signed by the inspector.**