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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions 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
May 5, 2016	2016_289550_0013	004357-16	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

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

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

JOANNE HENRIE (550)

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): March 29, April 4 and 5, 2016.

This inspection included a complaint under Log O-004357-16 related to the plan of treatment and another complaint under Log 000464-16 a complaint related to personal care and falls.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, a registered staff, personal support workers and three family member. The inspector also reviewed two resident's health care records, policies regarding management of concerns/complaints and medication.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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. The licensee failed to ensure that the resident, the SDM, if any, and the designate of

the resident / SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

During an interview, Resident #001's sibling reported that the resident's specific medication was held on a specific date in June, 2015 and that the family members were not made aware.

A review of the resident's health care records indicated that on a specific date in June, 2015, blood work result for resident #001 returned with an abnormal value. RN #S100 immediately called the physician who ordered to hold a specific medication for blood therapy, added a new medication and more blood work to be done monthly. A note beside the physician order by RN #S100 indicated "POA was informed". The inspector was not able to find any other documentation to indicate that the resident's substitute decision maker or other sibling were informed that a specific medication was on hold. On a specific date in January 2016, the resident was transferred to the hospital where a specific health condition related to the blood was identified. At that time it was discovered that the resident's specific blood therapy medication had been on hold since June 2015, and it was never re-evaluated when the blood levels returned to normal in August 2015.

During an interview with the resident's substitute decision maker, he/she indicated to inspector that when RN #S100 called him/her regarding the abnormal value, he/she was not made aware that the blood therapy medication was being held, he/she further indicated he/she would have questioned it because resident #001 has been taking this medication for many years.

During an interview, RN #S100 indicated to inspector she did not recall who she spoke with, she did not recall the exact conversation and she had no documentation to support her conversation with the resident's sibling.

The Administrator and the Director of Care both indicated to Inspector #550 that they have no documentation to support that RN #S100 informed the resident's substitute decision maker that the blood therapy medication was held.

As evidenced above, resident #001's substitute decision maker was not provided with the opportunity to participate fully in the development and implementation of the resident's plan of care.

This inspection is related to complaint Log #004357-16. [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 to ensure that resident #001 and the substitute decision maker are involved in the development and implementation of the resident'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. The licensee has failed to ensure that the resident have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

During an interview, resident #002's spouse indicated to Inspector #550 that the resident used a variable positive airway pressure (VPAP) machine every night. He/she indicated that the staff never cleaned the machine for the resident and when he/she picked up the machine at the home to bring it to the hospital when his/her spouse was admitted on a specific date in December 2015, the machine was visibly dirty with dried food matter and dried saliva.

The Administrator and the Director of Care both indicated to the inspector that the home did not have any procedures in place at the time to clean the resident's VPAP machine therefore the resident's VPAP machine was not cleaned by staff.

This inspection is related to complaint log #000464-16. [s. 37. (1) (b)]

Issued on this 6th day of May, 2016

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

Original report signed by the inspector.