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
Aug 28, 2014	2014_200148_0027	O-000763-14	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), MELANIE SARRAZIN (592), RUZICA SUBOTIC-HOWELL (548), SUSAN WENDT (546)

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): August 18- 22, 2014 and August 25-27, 2014.

This inspection also included two complaints Log #O-001245-13 and Log #O-000245-14.

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Director of Care (DOC), Staff Development/Nurse Manager, Resident Service/Resident Assessment Instrument (RAI) Coordinator, Recreation/Restorative care Manager, Environmental Services Manager, Nurse Manager, Registered Nurses, Registered Practical Nurses (RPN), Personal Support Workers (PSW), Activity Assistant, Physiotherapy Assistant (PTA), Restorative Aid, Food Service Workers, Housekeeping aids, Resident Council members and a Family Council member.

During the course of the inspection, the inspector(s) reviewed resident health care records, policies including infection control, continence care, falls prevention program and the home's pain management program. In addition, documents were reviewed related to the activity program and the home's nursing staffing plan, along with resident and family council meeting minutes. The inspectors also observed resident care, staff-resident interaction and meal service.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that the written plan of care for Resident #2 sets out the planned care for the resident, related to physiotherapy services.

The current plan of care for Resident #2 indicates the provision of the following physiotherapy interventions as it relates to decreased strength/balance, impaired posture and arthritic knee pain:
- Biofreeze to knee, as needed
- Paraffin wax to hands, as needed
- Perform standing balance exercises
- Perform strengthening exercises
- Performs range of motion exercises
- TENS therapy

The most recent assessment completed by the Physiotherapist (PT) does not indicate the provision of bio-freeze, paraffin wax or balance, strength or range of motion exercises.

The Physiotherapy Daily Attendance sheets, used by the home to record the provision of physiotherapy services, for 2 months were reviewed, which indicates that balance and range of motion exercise were not provided since the most recent PT assessment.

On August 21, 2014, PTA #S104 responsible for the provision of physiotherapy care to Resident #2, indicated that range of motion, strength and balance exercises, in addition to bio-freeze and paraffin wax, are no longer offered to the resident. At the present time the only physiotherapy treatment provided is the TENS therapy for pain relief.

The written plan of care does not set out the planned care for the resident, as it relates to the resident's need for physiotherapy. [s. 6. (1) (a)]

2. The licensee did not ensure that the care set out in the plan of care was provided to Resident #2, as specified in the plan.

Resident #2 suffers from arthritic pain.

The plan of care for Resident #2 indicates that the resident is to be provided strength,

balance and range of motion exercises. These interventions were initiated in early 2014 after an assessment by the Physiotherapist.

The Physiotherapy Daily Attendance sheets for May and June 2014 were reviewed. The May 2014 attendance sheet indicates that strength, balance and range of motion exercises were not provided to the resident during this month. The June 2014 attendance sheet indicates that no range of motion exercises were provided to the resident during this month and one session of balance training was provided.

Restorative Aid Staff member #S105, who was the PTA for the home in May and June 2014, reported to Inspector #148 that due to cut backs in therapy hours, this resident was not provided the balance, strength and range of motion exercises as planned. The plan of care related to the provision of physiotherapy exercises was not provided to the resident as set out in the plan of care.

In addition, the plan of care for Resident #2 indicates that the resident is to be provided TENS therapy for pain relief, three times each week. The most recent assessment completed by the Physiotherapist, indicates that the resident is to be provided the TENS therapy.

Resident #2 indicated to Inspector #148 that he/she found the TENS therapy to provide pain relief.

The Physiotherapy Daily Attendance sheets for July and August 2014 were reviewed. Documentation in July indicates that the TENS therapy was provided on 3 dates in July, noting two weeks without TENS therapy provided.

PTA Staff member #S104 reported to Inspector #148, that the TENS therapy was provided to the resident on a regular basis starting at the end of July 2014 to present. During the month of July 2014, the plan of care, related to the provision of TENS therapy, was not provide to the resident as set out in the plan of care. [s. 6. (7)]

3. The licensee did not ensure that the care set out in the plan of care was provided to Resident #18 as specified in the plan, related to the need for a personal assistive service device.

The health care record for Resident #18 indicates that the resident has poor upper body control, leans while seated in wheelchair and is not able to position him/herself.

On August 18, 2014, Resident #18 was observed in the resident's bedroom, by Inspector #148, seated in a wheelchair with a padded table top applied. The Inspector further observed a lap belt available for use but that was not applied at this time and was hanging off the sides of the wheelchair. RPN #S114 entered the room to provide care but did not apply the lap belt. On August 19, 2014, Inspector #148 observed Resident #18 in the resident's bedroom, seated in a wheelchair with a padded table top and lap belt applied.

The current plan of care for Resident #18 indicates the use both the table top and lap belt as required Personal Assistive Service Devices (PASD). It was confirmed through staff interviews that the resident is to have both the table top and lap belt applied when seated in his/her wheelchair.

The plan of care, as it relates to the use of PASDs for Resident #18, was not provided to the resident as set out in the plan on August 18, 2014. [s. 6. (7)]

WN #2: 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 did not ensure that the resident-staff communication and response system was easily accessible to Resident #16 and #19.

The plan of care for Resident #16 indicates that the resident requires assistance with activities of daily living. The plan of care related to transfers indicates that the resident is at high risk for falls and requires frequent reminders to call for assistance prior to attempting to stand.

On August 19, 2014, Resident #16 was being provided care by a PSW staff member. After care had been provided, the staff member vacated the resident's room. Inspector #148 observed the resident in his/her room, seated in a wheelchair. The resident-staff communication system is located at the resident's head of bed, the call bell cord was observed to be wrapped around the left side bed rail with the resident seated on the right side of the bed. The resident was not within reach of the call bell.

The plan of care for Resident #19 indicates the resident requires assistance with activities of daily living and is at risk for falls due to impaired mobility and attempts to get up without assistance. The plan of care related to risk of falls indicates the resident requires the call bell within reach.

On August 19, 2014, Inspector #148 observed Resident #19 to be seated in a wheelchair on the left side of the bed. The resident-staff communication system is located at the head of bed, the call bell cord was draped on the bed, laying in the middle of bed mattress. The resident was positioned away from the bed and not within reach of the call bell cord. When asked by the Inspector, the resident was able to indicate the use of the call bell and confirmed that he/she was not able to reach the call bell. [s. 17. (1) (a)]

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,
(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 did not ensure that Resident #15, 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.

Resident #15 was admitted in early 2013 and assessed as continent at that time, as indicated by the 24 hour Admission Assessment/Care Plan. A review of the most recent Minimum Data Set (MDS) Assessment indicates that the resident's continence status has changed. The resident is currently assessed as occasionally incontinent of bowel, occasionally incontinent of bladder, uses pads/briefs and needs extensive assistance with toileting by one staff.

The plan of care related to bowel continence indicates the resident is usually continent of bowel, interventions include to check with the resident and record bowel movements. The plan of care related to bladder continence indicates that the resident is occasionally incontinent of bladder due to loss of muscle tone and to refer to the toileting plan of care for interventions.

The plan of care related to toileting indicates that the resident requires extensive assistance with all toileting as the resident is not able to complete the task safely. Interventions include to ensure an unobstructed pathway to the washroom and to ensure call bell is within reach.

Interviews with PSWs, responsible for the resident's care indicate that the resident is usually able to identify the need to void but does not always verbalize the need. Physical and behavioural cues are used to identify when the resident requires

assistance to the toilet, such as when the resident pulls on his/her pants. Staff indicate that the resident is not on a toileting schedule.

Inspector #148 spoke with the home's DOC who confirmed that continence assessments are to be recorded within the assessments of the resident's electronic health care record (otherwise known as Point Click Care). In the presence of the DOC, the electronic record was reviewed and no continence assessments were found. Upon further review of the available continence assessments, within the assessments of Point Click Care, it was determined that both available continence assessments were "retired" indicating that they are no longer available for used by staff. Inspector #148 requested the home's policy related to continence assessment. The home's DOC provided a policy entitled Continence Care (#LTC-E-50), which indicates that a 3 day continence assessment will be completed on admission and/or if there is a change in the level of continence.

It was determined that the continence care needs of Resident #15 have changed and that no assessment of continence has been completed using a clinically appropriate instrument. [s. 51. (2) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when Resident #7's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for the is purpose.

The health care record of Resident #7 indicates that the resident has chronic pain and frequently complains of pain. The MDS Assessment of March 2014 indicates the resident had no pain in the last 7 days in relation to the Assessment Reference Date. The MDS Assessment of June 2014 indicates the resident has moderate pain, less than daily.

Resident #7 reported to Inspector #148, on August 18 and 22, 2014, that the pain never seems to go away. RN #S113 and RPN #S114 both indicated that the pain has been ongoing for many months and they are aware of the resident's frequent complaints of pain.

The current plan of care for Resident #7 indicates the resident has chronic pain. Interventions include the use of routine and breakthrough pain medications and assessing the pain using an appropriate monitoring tool with a goal to improve pain within 1 hour of the intervention.

The resident had a physician order for pain medication. On a specified date, the resident returned from a hospital admission with an increase in pain medication.

Resident #7 has had ongoing complaints of pain. Pain medication was increased after a hospital admission. The resident's pain was not relieved by interventions implemented and the resident's pain has not been assessed using a clinically appropriate assessment instrument. [s. 52. (2)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee did not ensure that copies of the inspection reports from the past two years for the long-term care home are posted.

In accordance with O.Reg 79/10, s.79(1) and (3), the home shall ensure that required information, including copies of the inspection reports from the past two year for the home, are posted in the home, in a conspicuous and easily accessible location.

Inspector #148 observed the posting of required information as indicated by section 79(3) of the Regulations. The July 2, 2014 critical incident inspection was posted in the home on the main bulletin board on the first floor.

It was confirmed, that the October 11, 2014 complaint inspection, the October 7, 2014 critical incident inspection, the August 13, 3013 critical incident inspection, the January 23, 2013 critical incident inspection and the September 17, 2012 complaint inspection were not posted in the home. [s. 79. (3) (k)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee did not ensure that advice of the Residents' and Family Councils were sought out in the development and carrying out of the satisfaction survey.

The home's Administrator and Recreation/Restorative Care Manager, confirmed that the implementation of the most recent satisfaction survey was May 2014. It was reported that 2014 was the first year in which approximately half of the home's population would be surveyed in the spring and the remaining half would be surveyed in the fall.

Inspector #148 spoke with Resident #20 and #24, who are both active in the Resident Council. Both resident's could identify that a survey had been implemented in the spring of 2014, however, neither resident could recall the home seeking out the advice of the Residents' Council, related to the survey's development and carrying out, prior to the implementation of the spring 2014 survey.
Inspector #148 spoke with Family member #S115, who is active in the Family Council. The Family member could not recall the home seeking out the advice of the Family Council, related to the survey's development and carrying out, prior to the implementation of the spring 2014 survey.

Inspector #148 reviewed the Family and Resident Council meeting minutes which demonstrated that both councils were reminded to complete the surveys. The minutes did not reflect that either of the councils were given an opportunity to provide advice on the development or carrying out of the survey.

Inspector #148 spoke with the home's Administrator who reported that it was expected that the liaison to the councils would have reviewed the satisfaction survey with the Residents' and Family Council in March/April 2014. The liaison working with the councils at this time is no longer available in the home to confirm. When asked, the Administrator acknowledged, that a review with the Councils in March/April 2014 would not have allowed for sufficient time to incorporate or change aspects of the development or carrying out of the survey for the May 2014 implementation. [s. 85. (3)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee did not ensure that drugs must be destroyed by a team acting together and composed of (i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and (ii) one other staff member appointed by the Director of Nursing and Personal Care. Specifically, the licensee failed to ensure that non-controlled substances are destroyed by a team acting together and composed of members as described by this section.

On August 25, 2014 LTCH Inspector #548 conducted a review of the home's medication management system, including the home's process and procedures for the destruction and disposal of medication for controlled and non-controlled substances.

On August 25, 2014 during an interview with registered nursing staff, Staff #126 and Staff #127, both indicate that the disposal of non-controlled substances includes the removal and disposal of the non-controlled substance where it is s placed in an appropriate medication disposal container locked in the medication room by two registered staff members until its removal by the pharmacy provider.

On August 25, 2014 both registered nursing staff, Staff #126 and Staff #127, both reported that non-controlled substances in their original packaging are placed in the medication disposal container until its removal from the medication room by the home's pharmacy provider.

On August 25, 2014 during an interview the Director of Care confirmed that the process for the destruction of non-controlled substances includes: the identification to remove the non-controlled substance from circulation, documentation of its removal by two registered nursing staff members and placement in an non-manipulated medication disposal container until it is removed by the home's pharmacy provider to be destroyed.

Further, the Director of Care indicated she was not aware that a team acting together as per O. Reg 79/10 section 136 (3) was a requirement for the destruction of non-controlled substances and as per O. Reg 79/10 section 136 (6) that the drug is destroyed or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (3) (b)]

Issued on this 2nd day of September, 2014

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