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
Jul 21, 2014	2014_163109_0022	T-592-14	Critical Incident System

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

HUMBER VALLEY TERRACE
95 Humber College Blvd., Rexdale, ON, M9V-5B5

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

SUSAN SQUIRES (109)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 27, July 9, 10, 2014.

During the course of the inspection, the inspector(s) spoke with administrator, director of care, assistant director of care, staff educator, wound care nurse, behavioural support staff member, registered nursing staff, personal support workers, physiotherapist, family member.

During the course of the inspection, the inspector(s) reviewed responsive behaviour and skin care policies, reviewed staff education records, reviewed identified resident's health record, observed an identified resident.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of the care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review and staff interview reveal resident # 1 was identified to have altered skin integrity present since his/her admission.

The front line staff interview revealed that staff had opinions about potential causes for the altered skin integrity.

Interview of the registered staff revealed they were unaware of the potential causes identified by the personal support workers.

The home's wound care nurse was not notified and is not involved in the assessment of the altered skin integrity or the development of the plan of care. [s. 6. (4) (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 staff and others involved in the different aspects of the care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behavior plan of care is based on an interdisciplinary assessment of resident #1 that includes the required components.

Resident #1 was identified through the progress notes to have almost daily responsive behaviours since his/her admission to the home.

The written plan of care does not describe mood and behaviour patterns, any identified responsive behaviours, or any potential behavioural triggers and variations in resident functioning throughout the day.

The written plan of care describes completing a referral to the Behavioural Support of Ontario (BSO) staff person as well as a referral to geriatric psychiatrist for the responsive behaviours which has not been completed.

The home has a responsive behaviour program which includes a BSO staff member. Interview with the BSO staff member indicates that he/she has not received a referral to assess this resident and assist the staff on the unit with planning the care and interventions to manage the responsive behaviours. [s. 26. (3) 5.]

2. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the residents' skin condition, altered skin integrity.

Record review, observation and staff interview reveal resident #1 has multiple areas of altered skin integrity. Resident #1 has had skin problems since being admitted to the home.

Resident # 1 sustained an altered skin integrity on an identified date. The progress note and staff interview indicate that it is unknown how the skin problem occurred.

Front line staff interview reveal that resident #1 slides down in his/her wheelchair and scrapes his/her arms which they believe may cause the altered skin integrity. Front line staff interview further reveals that resident #1 bangs his/her hands and arms on the bed rails which they believe may also cause the skin problems.

The registered staff were unaware of this information as to a possible cause for the altered skin integrity.

There is no plan of care in place for the actual and potential altered skin integrity and the actual and potential causes identified by the care staff. [s. 26. (3) 15.]

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 the responsive behavior plan of care is based on an interdisciplinary assessment of resident #1 that includes the required components, and that the plan of care is based on an interdisciplinary assessment with respect to resident #1's skin condition, altered skin integrity, to be implemented voluntarily.

WN #3: 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 resident #1 exhibiting altered skin integrity received 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.
Resident #1 has had altered skin integrity since admission to the home. There have been no skin assessments completed on the home's internal clinically appropriate assessment tool.
There is no indication in the health record or from staff interview when the wounds healed or if the wounds are getting better or deteriorating.
Currently the resident has at least 2 different types of wound coverings in place. The treatment records indicate that there is only one wound treatment.
There was a new alteration in skin integrity found on the resident on an identified date and there was no assessment completed for this wound using the homes clinically appropriate assessment tool. [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 o ensure that resident #1 exhibiting altered skin integrity received 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the behavioural triggers have been identified for resident #1 who is exhibiting responsive behaviours.

Resident # 1 was admitted to the home on an identified date. Within the first day of admission to the home the resident exhibited responsive behaviour toward the staff during care. The health record revealed that there were responsive behaviours identified almost daily from when the resident was admitted until an identified date when the resident was found with an injury.

Staff interview reveal that some of the staff state the resident is still resistive and aggressive on a daily basis, while other staff state the resident is rarely exhibiting responsive behaviours.

Staff interview and record review reveal no triggers have been identified for resident #1`s responsive behaviours. [s. 53. (4) (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 the behavioural triggers have been identified for resident #1 who is exhibiting responsive behaviours, to be implemented voluntarily.

Issued on this 28th day of July, 2014

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