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 soins 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
Jun 21, 2016	2016_188168_0014	017410-16	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

BAYWOODS PLACE
330 MAIN STREET EAST HAMILTON ON L8N 3T9

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

LISA VINK (168), LESLEY EDWARDS (506)

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): June 14, 15, 16, 17 and 20 2016.

During the course of this inspection the following inspections were conducted concurrently:
Critical Incident Inspections
003447-15 - related to transferring and positioning techniques
028054-15 - related to security of drug supply
028160-15 - related to pain management and transferring and positioning techniques
003747-16 - related to responsive behaviours
004792-16 - related to transferring and positioning techniques and complying with manufacturers specifications
003753-15 - related to responsive behaviours
17644-16 – related to falls prevention
Complaint Inspection
009825-16 - related to plan of care, bathing and Residents' Bill of Rights
Follow Up Inspection
007956-16 - related to inspection number 2015-188168-0002 - order #001

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care, Resident Services Co-ordinator/Staff Educator, Program Manager, Environmental Manager, Physiotherapist, staff from the office of the Public Guardian and Trustee Office, registered nursing staff, personal support workers (PSW), housekeeping staff, families and residents.

During the course of the inspection, the inspectors: toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to policies and procedures, meeting minutes, investigative notes and clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
8 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 s. 6. (4)	CO #001	2015_188168_0002	506

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home and equipment were kept clean and sanitary.

On June 14, 2016, during a tour of the home the bathtubs in the spa rooms were observed to not be clean and sanitary. Four out of the five bathtubs observed were identified to have a layer of debris and dust surrounding the interior of the tubs. Interview with the Administrator confirmed that tubs were currently not in use at this time; however, the expectation was that the tubs were to be kept clean and sanitary at all times and ready for resident use.
The home and equipment were not kept clean and sanitary. [s. 15. (2) (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 home and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #2: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

Resident #120 had an physician's order to receive a specified medication monthly, via injection. The resident was known to resist the medication and would frequently refuse. As a result of the ongoing non-compliance and negative impact to the resident's overall health, a Community Treatment Order (CTO) was put in place in 2015 to ensure compliance. According to the clinical record the resident was required to receive the medication on April 1, 2016, as ordered by the physician. The resident refused to the take the medication on April 1, 2016, as ordered, according to Medication Administration record and interview with the DOC and registered staff #203. The home did not follow the CTO nor take the necessary action to ensure compliance with the medication on April 1, 2016. The home attempted to administer the medication a second time in April 2016, again without success and on this day the resident was transferred to hospital for treatment of another medical condition. The medication was not administered every four weeks, as prescribed by the physician when it was refused on April 1, 2016 and the home did not take the necessary steps to ensure compliance as confirmed by the DOC. The drug was not administered to a resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drug is administered to a resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

Resident #125 resided on a secured unit where residents were able to wander in a safe environment. A review of the plan of care for resident #121 identified that on four occasions between October to November 2015, the resident attempted to or wandered into resident #125's room. Resident #125 demonstrated responsive behaviours to the co-resident when they entered their room in an attempt to get them to leave the space. A review of the plan of care for resident #125 identified a focus statement related to

responsive behaviours which included "verbally abusive towards staff and co-residents, socially inappropriate at times, refusal of care due to impaired cognition (dementia)". The plan of care did not address the specific trigger of the resident not wanting other residents to enter their room nor the interventions that the staff had in place to address the concern, as confirmed during an interview and plan of care review by registered staff #204.
The plan of care did not give clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #120 had a physician's order to receive a specified medication monthly, via injection. The resident was known to resist this medication and would frequently refuse. As a result of the ongoing non-compliance and negative impact to the resident's overall health, a Community Treatment Order (CTO) was put in place in December 2015 to ensure compliance. A review of the plan of care did not include the resident's CTO nor the actions to be taken by staff when the medication was refused. Interview with the DOC and registered staff #203 confirmed that the CTO and required actions of staff should be included in the plan of care. The DOC confirmed that the plan of care did not include the CTO, other than in the physician's order section of the clinical record and that this information has since been posted in the medication room, in a discreet place at the nursing station and in the plan of care as was an assessed need of the resident.
The plan of care was not based on the needs of the resident. [s. 6. (2)]

3. The licensee failed to ensure that the resident's plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #116's plan of care indicated that the resident was to use a chair and bed alarm to help mitigate the risk for falls. An observation of the resident on June 16, 2016, confirmed that the resident was not using an alarm. Interview with PSW #202 confirmed the resident was no longer using the alarm and had not for quite some time. Registered staff #203 confirmed that the plan of care should have been reviewed and revised as the care needs had changed.
The plan of care was not reviewed and revised with changes in the resident's care needs. [s. 6. (10) (b)]

4. The licensee failed to ensure the plan of care was revised when care set out in the

plan had not been effective and that different approaches were considered in the revision of the plan of care.

Resident #113 sustained a fall in September 2015. During the initial post fall assessment the resident did not have any signs or symptoms of an injury or any pain. The resident started to experience symptoms of pain and decreased mobility two days later. The registered staff's assessments of the resident's pain and decreased mobility indicated the resident verbally expressed they were in pain, was crying, hollering out in pain and communicated at times that their pain was reaching the highest pain level which was ten out of ten. Four days following the fall the home had the physiotherapist assess the resident's decreased mobility and the physician ordered testing. The testing was completed two days after they were ordered and the result suggested an injury in an identified area; however, it was suggested a CAT scan be completed. The resident was sent to the hospital the following day, where it was confirmed that the resident sustained an injury. During the identified time period post fall until transport to hospital on the seventh day after the fall, when the resident experienced pain, the staff did not offer the resident any medications to relieve their symptoms of pain. The DOC confirmed when the resident's plan of care had been revised due to the care not being effective different approaches for pain management were not considered.
The plan of care was not revised when care set out in the plan had not been effective and different approaches were not considered in the revision of the plan of care. [s. 6. (11) (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 to ensure that there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident, that the resident's plan of care is reviewed and revised when the resident's care needs change and that the plan of care is revised when care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #4: 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 failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

At approximately 1455 hours, change of shift, on October 6, 2015, registered staff located one tablet of a controlled substance on the floor in the medication room and identified during the narcotic count, that two partial medication cards, which were to contain a total of 6 tablets, of an identified narcotic were missing from the separate locked area, the narcotic bin, in the medication cart, which was stored in the medication room. Registered staff #207 worked on the identified shift when the narcotics went missing. The staff member confirmed, during an interview, that to her recall the medications were present and the medication cart and the bin were locked when she left the medication room at approximately 1400 hours to carry out other responsibilities; however, the medications were not present at 1455 hours. The staff also identified that at the time of the incident the narcotic bin was full with medication cards and at times the self locking lid to the bin did not engage when it was closed due to the cards. It was identified during the course of the internal investigation conducted by the home that the medication door required to be manually pulled closed at times to ensure that the door locked securely.
Controlled substances were not stored in a separate locked area within the locked medication cart when they went missing on the day shift of October 6, 2015. [s. 129. (1) (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 to ensure that controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that residents were transferred using safe transferring and positioning techniques.

In February of 2015, resident #115 was transferred by two PSW staff using a sit to stand lift to the toilet. The resident slipped and sustained an injury during the transfer and was transferred to the hospital for assessment. The resident's plan of care indicated that the resident was to use a hoyer lift for all transfers as the resident was not able to weight bear. The DOC confirmed that the PSW's did not follow safe transferring techniques and the resident sustained an injury.
The resident was not transferred using safe transferring and positioning techniques. [s. 36.]

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 residents are transferred using safe transferring and positioning techniques, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's "Skin and Wound Program, LTC-E-90, last revised August 2015" identified that: "all residents exhibiting altered skin integrity will be assessed by the nurse on initial discovery and re-assessed with every dressing change but minimum weekly", that "the nurse and wound care champion will be informed of all altered skin integrity", that "the nurse/wound care champion will complete a referral to Nutritional Care/Registered Dietitian for all residents exhibiting altered skin integrity" and that "skin breakdown will be documented by the UCP (unregulated care provider) either on POC (point of care) or paper and by the nurse in the interdisciplinary progress notes and the resident's care plan".

Resident #101 was identified to have a small area of altered skin integrity by the Inspector on June 14, 2016. This area was reported to nursing staff who provided care to the resident on June 15, 2016. The staff assessed the area on June 15, 2016 and recorded the area and their assessment in the progress notes. During a review of the clinical record on June 16, 2016, there was no communication to the nurse and wound care champion regarding the area, no referral to Nutritional Care/Registered Dietitian and the area was not included on the plan of care. The DOC was asked to review the clinical record on June 16, 2016, related to the area of altered skin integrity and on June 17, 2016, confirmed that staff did not comply with the home's program as identified. It was identified on June 17, 2016, that the resident had a referral to the wound care champion and Registered Dietitian during the evening shift on June 16, 2016 and that the plan of care included a focus statement related to the area of altered skin integrity, as required in the home's program.
The plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was not complied with. [s. 8. (1) (a),s. 8. (1) (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 to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #7: 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:
8. Continence, including bladder and bowel elimination. 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:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

Resident #100 was identified, on the most recent Minimum Data Set (MDS) assessment, dated April 8, 2016, as frequently incontinent of bowel and bladder. A review of the current plan of care did not include a focus statement related to their bowel or bladder elimination. Interview with registered staff #212 confirmed that the resident had bowel and bladder incontinence and that the plan of care did not address bowel and bladder elimination.
The plan of care was not based on the assessment of the resident's continence status for bowel and bladder functioning. [s. 26. (3) 8.]

2. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Resident #100 returned from the hospital in June 2016, with a catheter in place. The resident continued to be catheterized for ten additional days until an order was received from the physician for the removal of the device. The plan of care, which was in place for the identified period of time was reviewed and did not include the use of the catheter, as identified during an interview with registered staff #212. [s. 26. (3) 18.]

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 resident's plan of care is based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination and the resident's special treatments and interventions, to be implemented voluntarily.

WN #8: 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 residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were assessed at least weekly by a member of the registered nursing staff.

Resident #103 was identified to have an area of altered skin integrity in September 2015. The open area increased in size and the resident was referred to a specialist who diagnosed the area. The area of altered skin integrity was initially assessed when discovered in September 2015; however, weekly skin assessments were not completed since the initial assessment completed in September 2015, which was confirmed during a record review and interview with registered staff #205. The DOC confirmed that based on the home's policy and procedure weekly wound assessments to the area of altered skin integrity should have been completed.
The resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was not assessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that the Residents' Council was responded to in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Residents' Council Meeting Minutes and interview with the Administrator confirmed that not all concerns or recommendations were responded to in writing, to the council within 10 days of receipt. A review of Meeting Minutes did not include written responses for the following concerns identified:
i. During the March 18, 2015, meeting concerns/recommendations were raised related to there not being enough linen or towels in all home areas. These concerns were responded to during the Residents' Council meeting that was held April 29, 2015.
ii. During a meeting held in the Spring of 2015, concerns/recommendations were raised that the Council wanted iced tea on the menu more often. These concerns were not responded to.
iii. During a meeting held in the Spring of 2015, concerns/recommendations were raised related to a fuel truck parked beside the smoking gazebo and suggested it go in the back entrance. These concerns were not responded to.
iv. During the February 24, 2015, meeting concerns/recommendations were raised regarding the key pad to the exit to the smoking gazebo. These concerns were not responded to until March 30, 2016.
It was confirmed by the Administrator that the responses to concerns were not consistently being completed within 10 days.
Residents' Council was not responded to in writing within 10 days of providing advice related to concerns or recommendations to the home. [s. 57. (2)]

Issued on this 4th day of July, 2016

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

Original report signed by the inspector.