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
Sep 27, 2013	2013_184124_0021	O-534-13	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

REACHVIEW VILLAGE
130 REACH STREET, UXBRIDGE, ON, L9P-1L3

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 23, 24, 25, 2013

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator, Director of Care, Assistant Director of Care, Registered Practical Nurses, Personal Support Workers and the Consulting Pharmacist.

During the course of the inspection, the inspector(s) completed walking tours of the home, observed staff-resident interactions, made general observations regarding resident care, reviewed resident health records and the home's "Admission and Annual Care Conference", "Medication Reconciliation" and "Readmission from Hospital" policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Hospitalization and Death

Findings of Non-Compliance were found during this inspection.

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

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).

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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other 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.

Resident #1 has diagnoses of hypertension, arthritis and anemia.

It is documented in Resident #1's admission note that a family member reported the resident had chronic anemia.

The Health Assessment Form sent to the home as part of Resident #1's application to long term care listed a number of diagnoses including anemia.

Staff #101 reported to the inspector that on admission all residents' Medication Reconciliation and Admission Order Forms are completed and sent to pharmacy. Resident #1's Medication Reconciliation and Admission Order Form included a physician's order for a specific medication. The form did not include the resident's diagnosis of anemia.

A Medication Regimen Review Pharmacist Recommendation Form for Resident #1, five months after admission, posed the question, "Consider reassessing the need for the specific medication?" Staff #102 reported to the inspector that up to seven months after admission, the pharmacy did not have Resident #1's diagnosis of anemia and because the resident's blood work was normal, the pharmacist raised the question of whether or not the resident needed the specific medication.

Six months after admission, Resident #1's physician discontinued the medication and by a specific date, Resident #1's blood level was outside normal range. Three days later, the physician wrote an order for Resident #1 to be sent to the Emergency Room for treatment.

Omitting the resident's diagnosis of anemia from the information shared with pharmacy interfered with pharmacy's ability to collaborate with the physician to develop a plan of care that was consistent with the resident's needs. [s. 6. (4) (b)]

2. The licensee failed to ensure that Resident #1 was given an opportunity to participate fully in the development and implementation of the plan of care.

Resident #1's MDS assessment of a specific date described the resident as being independent in decision making and it was documented that the resident's Cognitive Performance Scale rating was 0/6.

On admission to the home, Resident #1 was prescribed medication and on a specific date the physician discontinued the medication.

During the inspection, Resident #1 reported to the inspector that he/she was never advised that the medication was being discontinued. [s. 6. (5)]

3. The licensee failed to ensure that Residents #1, #2 and #4 received care as set out in the plan of care.

On a specific date, Resident #1's physician ordered bloodwork to be done on a monthly basis.

Staff #100 reported to the inspector that Life Labs comes to the home on the first Friday of every month for the regularly scheduled bloodwork.

Results of the bloodwork for Resident #1 were recorded for the first six months after admission. During the seventh month after admission, it was documented in the progress notes that when a family member asked for an update on Resident #1's bloodwork, the family member was advised that the bloodwork had not been done that month. Resident #1's bloodwork was then completed.

Staff #100 reported that on the Emergency Record for Resident #1, the physician had recommended that Resident #1 have weekly bloodwork until stable.

Resident #1's bloodwork was monitored weekly for four weeks. On a specific date, it was documented in the progress notes that Resident #1 did not have bloodwork completed on the fifth week.

Resident #2 was admitted to the home on a specific date.
On the Admission and Annual Medical Form, Resident #2's physician has identified a number of diagnoses.

At time of admission, Resident #2's physician wrote an order for weekly bloodwork. Resident #2's bloodwork was completed for five weeks. Staff #100 confirmed that Resident #2 did not have blood work completed on the sixth week.

Resident #4 has diagnoses of dementia and diabetes.

On the Physician Medication Review of a specified date, it was documented that Resident #4 was to have monthly bloodwork.

Staff #100 confirmed that Resident #4 did not have bloodwork completed for one specific month.

Residents #1, #2 and #4 did not have their blood work monitored as directed by their plans of care. [s. 6. (7)]

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 receive care as directed by their plan of care especially related to bloodwork, to be implemented voluntarily.

Issued on this 8th day of October, 2013

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

JMcPauland for LHamilton.