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

Division de la responsabilisation et de la performance du système de santé
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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
Jul 7, 2015	2015_258519_0021	010411-15	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

SUMMIT PLACE
850-4TH STREET EAST OWEN SOUND ON N4K 6A3

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

SHERRI GROULX (519), CAROLYN MCLEOD (614), DOROTHY GINTHER (568)

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 16, 17, 18, 19, 23, 24, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Environmental Services Manager, the Recreation Manager, the Resident Assessment Inventory/Minimum Data Set (RAI/MDS) Coordinator, the Registered Dietitian, the Nutrition Manager, Activation Staff, three Registered Nurses, three Registered Practical Nurses, six Personal Support Workers (PSW), Residents, and Families.

The Inspectors toured the home, observed meal service, medication passes, medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During observations on a specified date, a Resident was observed with bed rails in the raised position.

Record review revealed that the Resident required the use of side rails as a Personal Assistance Services Device (PASD) to assist with bed mobility. Review of the home's policy, LTC-K-10 Appendix B, indicated that informed consent is needed for the application of the PASD.

On a specified date, the Resident Assessment Inventory (RAI) Coordinator acknowledged that the Resident's side rails had been classified as a PASD in that the Resident used them for repositioning and bed mobility. The staff member confirmed that consent by the Resident or the Substitute Decision-Maker (SDM) of the Resident had not been obtained for the PASD. (568) [s. 8. (1) (b)]

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

On a specified date, the bed of a Resident was observed to have a side rails in the raised position.

Interviews with both the Resident and the Registered Practical Nurse (RPN) revealed that when in bed the Resident used the side rails for bed mobility. The Resident was able to get out of bed on their own.

The home's policy titled, "Seat Belts, Table Top/Tray, Side Rails", LTC-K-10 Appendix B, stated that under PASD, "need informed consent".

In the Resident's clinical record there was no evidence of informed consent for the use of side rails as a PASD. [s. 8. (1) (b)]

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

During resident observation on a specified date, it was noted that a Resident had bed rails in the raised position.

The clinical record indicated that the Resident used these bed rails as a PASD for support in bed mobility and to transfer safely.

On a specified date, the Registered Nurse (RN) could not find a consent form on the Resident's chart.

Upon interview with the RN on a specified date, it was confirmed that the home did not have a consent for PASDs. She stated they had a decision tree that would be utilized shortly but the staff have not been trained to use this form yet.

The home's policy titled, "Seat Belts, Table Top/Tray, Side Rails", LTC-K-10 Appendix B, stated under PASD, "need informed consent". [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 #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On a specified date, a Resident was observed in bed with the bed rails raised. Interview with a Personal Support Worker (PSW) revealed that when the Resident wants to, they can use their bed rails to assist with repositioning and bed mobility.

Record review did not reveal an assessment with regards to the Resident and their use of side rails. Interview with the RN and Lead for the Restraints program revealed that they were currently being trained on the use of a new assessment tool entitled, "Side Rail and Alternative Equipment Decision Tree". The staff member confirmed that once this training was completed the assessment tool would be implemented. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On a specified date, the bed of a Resident was observed with the bed rails raised. Upon interview with the Resident and the RPN it was revealed that the Resident used the side rails for bed mobility.

Record review did not reveal an assessment with regards to the Resident and their use of side rails. Interview with the RN and Lead for the Restraints program revealed that they were currently being trained on the use of a new assessment tool entitled, "Side Rail and Alternative Equipment Decision Tree". The staff member confirmed that once this training was completed the assessment tool would be implemented. [s. 15. (1) (a)]

3. The licensee has failed to ensure that where bed rails are used the resident has been assessed and his or her bed system is evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During Stage One observations of the Resident Quality Inspection (RQI), it was noted that a Resident had the bed rails raised.

The clinical record indicated that the Resident used the bed rails as a PASD for support for bed mobility and transferring. The clinical record also indicated that the Resident required the assistance of one to two staff to transfer from the bed to the wheelchair.

Upon interview with the RPN on a specified date, it was stated that the Resident used these bed rails to assist in moving from side to side in bed when the PSWs were providing care.

Upon interview with the RN on a specified date, it was confirmed that the home did not have a formal assessment of the resident in the bed with the bed rails. She stated that the Registered Staff document the use of the bed rails in the Quarterly Review and the Annual Review as well as in the Care Plan. She stated that there was a decision tree that has been developed but the staff have not been trained to use it yet. She stated that consent for the PASDs was verbal and not officially documented on a form. [s. 15. (1) (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 where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 10. Recreational and social activities

Specifically failed to comply with the following:

s. 10. (2) Without restricting the generality of subsection (1), the program shall include services for residents with cognitive impairments, and residents who are unable to leave their rooms. 2007, c. 8, s. 10 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Recreational and Social Activities Program include services for residents with cognitive impairments and residents who are unable to leave their room.

During multiple observations on specified dates, a Resident was observed in two different places in the home. The Resident had their eyes closed and was not interacting with staff or other residents.

Staff interview with a Programs staff revealed that the Resident had a cognitive impairment and was not able to participate in many of the group activities. The Resident enjoyed music and staff would bring them down if there was entertainment. When possible, staff would also provide some one to one music programming.

Record review revealed that in a select month the Resident attended four programs. There was no documentation that the resident was offered or received any one to one programming. In a select month the Resident attended two activities. There was no documentation that the Resident was offered or received any one to one programming during the select month.

Staff interview with the Recreation Manager revealed that the home did offer a variety of one to one programs for residents with cognitive impairments or for those residents that were unable to leave their room. These programs included: hand massage, reading, music appreciation and one to one chats. The home's goal was to provide residents with four one to one visits each month, particularly for residents that were unable to participate in the group programs. The Recreation Manager acknowledged that the Resident would not be able to participate in many of the group activities and that one to one programs would be important for this resident. The staff member acknowledged that their department needs to do more to ensure that residents with cognitive impairments were offered one to one services. [s. 10. (2)]

WN #4: 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 has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with the Recreation Manager, who was also the Resident Council appointed assistant, on a select date, it was confirmed that the home did not seek the advice of Resident Council in developing and carrying out the satisfaction survey. She stated that the survey comes straight from the Revera Head office and did not have the input from the Resident Council at the home. [s. 85. (3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

During the resident observation in Stage One, it was observed that the toilet roll holder in a common washroom, was rusted and corroded. This was confirmed both visually and verbally by the Environmental Services Manager. [s. 90. (2) (d)]

Issued on this 7th day of July, 2015

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

Original report signed by the inspector.