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
Dec 3, 2015	2015_258519_0036	026857-15	Resident Quality Inspection

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

Long-Term Care Home/Foyer de soins de longue durée

ST ANDREW'S TERRACE LONG TERM CARE COMMUNITY
255 St. Andrew's Street CAMBRIDGE ON N1S 1P1

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

SHERRI GROULX (519), DEBORA SAVILLE (192), NATALIE MORONEY (610), NUZHAT UDDIN (532)

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): November 17, 18, 19, 20, 23, 24, 25, 26, 2015

The following Critical Incident Inspections were completed within this RQI: #011735-15 (C.I 2926-000032-15), #019622-15 (C.I 2926-000044-15), #006598-15 (C.I 2926-000025-15), #030129-15 (C.I 2926-000053-15), #024646-15 (C.I 2926-000048-15)

PLEASE NOTE: A Written Notification (WN #1, 1 and 2), and Compliance Order under r.51(2)(a)identified in this report (Log#026857-15) will be issued under a Complaint Inspection #2015_226192_0062 Log #023170-15 concurrently inspected during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Manager of Resident Care, the Director of Clinical Education, the Assistant Manager of Resident Care, Minimum Data Set Quality Improvement Coordinator, the Manager of Life Enrichment, the Manager of Environmental Services, the Manager of Dietary Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Student Nurses, the Family Council Representative, 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:

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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
6 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 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

On a select date and time, a Resident requested use of a personal assistive device and was provided assistance by a Personal Support Worker (PSW). The Resident was using the personal assistive device and the staff member indicated they would return to assist the resident. Upon the staff member's return a few minutes later, the Resident indicated that they were not ready for assistance at that time. The Resident was then left and was not provided care for a three hour period. The PSW who assisted the Resident reported to the home that the resident was not assisted for an extended period of time.

The plan of care in effect at the time of the incident failed to identify the need for the personal assistive device and failed to provide guidance to staff providing care.

Review of the plan of care for the Resident with the Manager of Resident Care (MRC), identified that the plan of care had been updated two and a half months following the incident involving the Resident.

The licensee failed to ensure that the plan of care for a Resident provided clear direction to staff and others who provided direct care to the Resident when the Resident was left on a personal assistive device for a period of greater than three hours. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others who provided direct care to a

resident, were kept aware of the contents of the plan of care and had convenient and immediate access to it.

On a select date and time, a Resident requested to use a personal assistive device. A staff member assisted the Resident with this personal assistive device, leaving the light over the bed on and stating that they would return shortly. The staff member did return, however the Resident was not ready for assistance at that time. The staff member indicated, in an interview, that he/she left the Resident with the over bed light on and the door closed. Several hours later, the Resident was found by another Personal Support Worker (PSW) to still require assistance.

The plan of care for the Resident indicated under potential for injury related to Personal Assistive Services Device (PASD) that the Resident used a personal assistive device and was to be checked hourly.

During an interview on a select date and time, the PSW responsible for assessing the Resident indicated that they were not aware of the Resident's need to be checked hourly. The staff member indicated that the plan of care was available at the care centre, but that he/she was not aware of what information it contained.

The licensee failed to ensure that staff and others who provide direct care to a Resident, were kept aware of the contents of the plan of care. [s. 6. (8)]

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 plan of care set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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 was complied with.

The home's policy titled, "Delegation of Treatment to UCP'S", Policy Number RCM 05-09, stated under Documentation Procedure, "the RN or the RPN will identify the treatments are to be completed by the UCP. In the direction line of the TAR "PSW applied" will be added to the order to denote PSW application. The RN or RPN will sign off the TAR once the treatment has been reported as completed by the UCP. The TAR's direction line will include, "PSW applied" this then denotes that the RN or RPN is signing off that the treatment was provided by the PSW".

Record review for three Residents revealed that all three Residents had an order for a treatment cream to be applied on affected areas.

The Manager of Resident Care (MRC) confirmed with a Registered staff on the phone that the creams were being applied by the Personal Support Worker (PSW).

In an interview on a select date, the MRC confirmed that the PSW staff were applying the treatment cream in the home as delegated, however, the Registered staff were not identifying on the Treatment Application Record (TAR) that the PSWs were applying the treatment creams and there were no notes stating "PSW applied." The MRC also confirmed that this policy was not being followed for any of the Residents that were on the list for PSW staff to apply the treatment creams.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with when the Registered staff were signing off on the TAR and not indicating on the TAR "PSW applied, as it appeared that the treatment was provided by them. [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 was complied with, to be implemented voluntarily.

WN #3: 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 were used, the Resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

The plan of care for a Resident stated that the Resident used a personal assistive device and that the Resident was independent with transferring.

Upon interview with the Resident on a select date, they stated that they used a personal assistive device on one side of their bed but not on the other side, as they wanted to be able to self-transfer.

Upon interview on a select date and time, with the Registered Practical Nurse (RPN), it was confirmed that the Resident used the personal assistive device on the right side of their bed.

The home's policy titled, "Bed Rail Safety", Policy Number RCM 12-06, stated under Procedure that "The decision to use/not use bedrails should be recorded in the Care Plan. The Resident Mobility and Bed Rail Assessment will be completed by Registered team members 1. within 24 hours of admission, 2. following readmission from hospital or other LTC Homes, 3. when there is a significant change in health status, 4. following any incident related to safety in bed".

Record review revealed that there was no Mobility and Bed Rail Assessment completed for the Resident.

Upon interview on a select date and time, the Manager of Resident Care (MRC) confirmed that a Mobility and Bed Rail Assessment had not been completed for the Resident and acknowledged that the Resident was not assessed and the expectation was to have the Bed Rail assessment completed and bed systems evaluated in accordance with the evidence- base practice. [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 were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements:
(4) Monitoring of all residents during meals.

On a select date, during the dining room observation on a select home area, there were Residents in the dining room that were unsupervised with fluids served for all Residents on the tables.

On a select date, during Resident observation in the dining room on a select home area, all the fluids for lunch service were set out for the Residents on the tables. A Resident had two fluids set out in front of them and was reaching for the Resident's fluids next to them, who were not seated at the table yet. The Personal Support Worker (PSW) confirmed that the fluids the Resident was reaching for to drink were not their fluids.

The Dietary Aide confirmed on a select date, that their normal practice was to set out all fluids for meal service fifteen minutes prior to the meal times on all units.

According to the home's policy titled, "Meal Service Delivery", Policy Number FS 09-04, it stated under number 5, "the meal should be held in the steam table or the refrigerator until a team member is available to assist the resident with eating or drinking".

Upon interview with the Manager of Food Services on a select date, it was confirmed that they always put out all drinks fifteen minutes prior to meal time, and that the dining rooms were not supervised by staff prior to meal time.

The Licensee failed to ensure that all Residents were monitored during meals when the fluids were pre-poured and set at the tables fifteen minutes prior to meal service, and Residents had access to the fluids on the tables without staff supervision. [s. 73. (1) 4.]

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 has a dining and snack service that includes, at a minimum, the following elements:
(4) Monitoring of all residents during meals., to be implemented voluntarily.

WN #5: 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 has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On a select date and time on a select home area, a Registered Practical Nurse (RPN) was observed administering medication in front of the dining room and leaving the medication cart unlocked each time they administered medication to a Resident. It was observed that when the RPN left the medication cart unattended the medication cart was not in the RPN's line of vision.

This was observed to have occurred for six Resident medication administrations.

Upon interview on a select date, the Registered Practical Nurse (RPN) confirmed that the medication cart was not locked each time they left to administer medication in the two dining rooms and the one time down the hall. [s. 129. (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 drugs stored in an area or a medication cart, are secure and locked, to be implemented voluntarily.

WN #6: 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 has failed to ensure that the drugs were administered to Residents in accordance with the directions for use specified by the prescriber.

A Resident had a Physician's order for a treatment cream to be applied twice daily.

Upon interview on a select date, a Personal Support Worker (PSW) reported that they applied the treatment cream on the Resident as many times as the Resident requested it. The PSW confirmed that they applied the treatment cream more than twice a day, even though the directions on the Physician's order was for twice a day only.

Upon interview with the Assistant Manager of Resident Care (AMRC) on a select date, it was confirmed that the PSW staff who applied the Resident's treatment cream did not have the education or training related to the application of treatment creams.

Upon interview on a select date, the Registered Practical Nurse (RPN) confirmed that the treatment cream was to be applied in accordance with the directions for use by the prescriber and acknowledged that when PSWs apply the cream more than the prescribed amount, they were not following the directions. [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 the drugs administered to residents are in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Medication observation revealed on a select date and time on a select home area, that the Registered Practical Nurse (RPN) who was administering medication in front of the dining room left the Point Click Care Electronic Medication Administration Record screen open revealing the Resident's personal health information (PHI) including the Resident's plan of care, related to medication.

This was observed to have occurred for six Resident medication administrations.

Upon interview on a select date, the Registered Practical Nurse (RPN) acknowledged that the screen was left open with the Resident's PHI including the Resident's plan of care related to medication, and confirmed that they should have locked the screen and kept the Resident's PHI confidential in accordance with that Act each time they walked away from the medication cart. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

This will be issued as a Written Notification as there is an outstanding Compliance Order related to section 19(1), protecting residents from abuse by anyone and free from neglect

by the licensee or staff in the home.

On a select date, a Resident was assisted to bed by two Personal Support Workers (PSW) on a select shift. At a select time, the Resident activated their call bell to request assistance to change their position as they were uncomfortable. Shortly thereafter the Resident again activated their call bell to be repositioned.

Several hours later on the next shift, the Resident was heard to be calling out for help. The PSW responding found the Resident to be tearful. The staff member asked the Resident why they had not activated the call bell. The Resident indicated that when they had been put to bed, a staff member told them to not use the call bell for two hours. The Resident was able to identify the staff member.

During an interview with management of the home, the Resident provided consistent information with regard to the incident, was able to describe the staff member initiating the comment and was able to identify the staff member's photograph.

Interview with the Administrator confirmed that the Resident was emotionally distressed by the comment made by the staff member. The Administrator confirmed that the action of the staff member would meet the home's definition of emotional abuse of the Resident.

The licensee failed to protect a Resident from emotional abuse by a staff member in the home. [s. 19. (1)]

2. The licensee failed protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff.

This non-compliance will be issued as a Written Notification as there is an outstanding Compliance Order related to section 19(1) of the Act.

On a select date and time, the home reported to the Director that a Resident had not been assisted for a period of time greater than three hours, resulting in redness of the Resident's skin.

The home's investigation into the incident confirmed that at a select time a staff member had assisted the Resident with a personal assistive device at the Resident's request. The staff member indicated to the Resident that he/she would return in a few minutes to remove it. On return to the Resident, the Resident indicated they required additional time

before requiring further assistance.

In a written statement, the staff member confirmed that he/she had assisted the Resident, checked on the Resident, and then carried on with other duties. The Resident did not ring for assistance and the staff member became involved in meeting the needs of other Residents of the home area.

Several hours later a staff entered the room and discovered that further assistance was not provided to the resident as earlier required.

Neglect is defined as a failure to provide a Resident with the treatment, care , services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more Residents.

On a select date and time, a Resident was assisted with a personal assistive device. The Resident was neglected when staff failed to return to assist the Resident, who was dependent on staff for assistance. For a period of greater than three hours, the Resident was not assisted by staff, which caused pressure on the Resident's skin and put the Resident's health and safety at risk.

The licensee failed to protect the Resident from neglect by the licensee or staff. [s. 19. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that all menu substitutions were communicated to Residents and staff.

On a select date, the dessert for the lunch menu was orange sherbert or strawberries with topping.

A select home area was serving strawberry ice cream for lunch desert.

Upon interview with the Dietary Aide on a select date, it was confirmed that they did not have orange sherbert ice-cream.

The Manager of Food Services confirmed that it was the home's expectation that all menu substitutions should have been communicated to residents and staff.

The licensee failed to update the menu substitutions and communicate the change to residents and staff. [s. 72. (2) (f)]

Issued on this 4th day of December, 2015

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

Original report signed by the inspector.