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
Oct 2, 2014	2014_206115_0014	L-001230-14	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

RIVERSIDE PLACE
3181 Meadowbrook Lane, WINDSOR, ON, N8T-0A4

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

TERRI DALY (115), ALICIA MARLATT (590), ALISON FALKINGHAM (518)

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): September 15, 16, 17, 18, 19, 23, 24, and 25, 2014

Critical Incident 2972-000011-14 inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Dietary Manager, the Program Manager, the Resident Services Coordinator, the Environmental Manager, the Regional Clinical Care Coordinator, two Registered Nurses, nine Registered Practical Nurses, one Physiotherapy Assistant, fourteen Personal Support Workers, one Dietary Aide, three family members, and forty residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident home areas and common areas, observed a meal service, observed residents and care provided to them. Medication administration and storage areas were observed. Reviewed clinical records of identified residents, policies and procedures, meeting minutes, and other pertinent records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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. (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. (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 has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident, related to use of a wheelchair.

There is no documentation in the care plan regarding the use of the wheelchair.

Staff confirmed that it is the home's expectation that the care plan sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in different aspects of care related to PASD/Restraint usage collaborated with each other in the assessment of a resident, so that their assessments were integrated, consistent, and complement one another.

The specific devices are not included on the resident's plan of care, and there is no consent or physician's order for either device.

Staff confirmed that it is the expectation of the home that all potential restraining or personal safety devices be assessed. [s. 6. (4) (a)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care related to PASD/Restraint usage collaborated with each other in the assessment of a resident's use of a device, so that their assessments were integrated, consistent and compliment one another.

There is no informed consent, physician order or least restraint assessment completed for one of the devices.
The other device is not included in the care plan, and does not have a physician's order.

Staff confirmed that it is the expectation of the home that all potential restraining devices or personal safety devices be assessed. [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 clear directions are set out in the plan of care and that restraint/PASD assessments are integrated, consistent and complement one another, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency. O. Reg. 79/10, s. 9. (1).

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans. O. Reg. 79/10, s. 9. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour it was noted that the doors to a storage room were unlocked. A resident care cart with prescription treatment cream, and plastic razors was accessible to residents.

This was confirmed by staff.

Management confirms that the care cart storage doors are to be locked at all times. [s.9 (1)2.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Review of a resident's clinical record revealed a doctors order to assess and document in the progress note the measurements, colour change, pain level and signs of infection of the specified area, every week.

A review of the progress notes revealed that of the last 16 weeks there were only 6 weeks where an assessment per the doctors order was documented.

A staff member confirmed that the assessments have been completed but were not documented as ordered. [s. 30. (2)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Family Council concern was responded to in writing within 10 days.

A review of the Family Council meeting minutes reported that the residents enjoyed a specific activity, but that it is no longer played as items are missing. A request by family that new items be purchased was made, however the minutes indicate that the Executive Director will forward the concern to the Program Manager.
There is no response in writing related to this concern/recommendation.

A discussion with the Program Manager reveals that she was aware of the concern but that there has been no progress or follow up in relation to the matter.
The Executive Director indicates that there has been no response to family council but that it is the home's expectation that a written response be provided to Family Council within 10 days.

The Program Manager confirmed that the items have now been ordered. [s. 60. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident heights are measured annually after their original admission date.

A clinical record review revealed that 23/23 of the resident heights reviewed were not measured annually after their original admission date.

Staff confirmed that heights were only obtained on admission, however acknowledged that the expectation would be to ensure heights are recorded annually for all residents. [s. 68. (2) (e) (ii)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that the most recent Resident Council meeting minutes were posted.

Observation of the Resident Council bulletin board reveals meeting minutes posted from the June 2014 meeting only, records indicate Resident Council meetings were held in August and September 2014.

An interview with a Resident Council representative, confirmed that Resident Council meeting minutes are to be posted as per consent by the council.

The home's assistant to the Resident's Council confirmed that the meeting minutes for August and September were not posted as they were still in hand written draft format.

Management confirmed that it is the expectation of the home that the Resident Council meeting minutes are posted as soon as possible after the meeting. [s. 79. (3) (n)]

WN #7: 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 treatment medication is stored in an area that is secure and locked.
A prescription cream was found on the top of a care cart behind an unlocked door. This was confirmed by staff.
The cream was removed and brought to the medication room.

A plastic jar of prescription cream was found on a resident's bathroom shelf. This was confirmed by a registered staff member.

Management confirmed that it is the home's expectation that all medications are stored and locked in the medication room when not in use. [s. 129. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.
Well used resident equipment was found in a resident's room, the equipment contained debris, and had a foul odour.

An interview with staff revealed, that the resident receives treatment using this equipment, due to a disease process.
Staff indicate that the equipment is changed whenever the staff note it is dirty, and that this is not documented on the MARS, TARS or progress notes.

The same equipment was again observed in the same state, in the resident's room.

The Infection Prevention and Control Manual Cleaning/Disinfecting or Sterilization of Equipment Policy IPC-C-10-05 March 2014, indicates that equipment is cleaned weekly or as per regional requirements.

Management confirms it is the expectation that equipment be changed on a weekly basis or when it is observed to be unclean. [s. 229. (4)]

2. The licensee has failed to ensure that residents are offered immunizations against tetanus and diphtheria in accordance with publicly funded immunization schedules posted on the Ministry website.

Management confirmed that it is the expectation that these immunizations be offered to every resident on admission and they are in the process of obtaining consents and Doctors orders for these immunizations, but at this time residents have not received these immunizations. [s. 229. (10) 3.]

Issued on this 16th day of October, 2014

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