Annual Resident Quality Inspection - June 2014

Finding	Type of notification	What it means	How we resolved it
The licensee failed to 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. (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.	Written Notification Compliance Order	All beds need to be assessed using a special tool that measures the distance between the bed rail and mattress.	All beds were assessed and bed rails removed within two months. Our policies, education to staff and communication to residents and families occurred within this same two months. The Ministry revisited our home on September 25 and they were satisfied with the new program in place.
Licensee has failed to comply with O. Regulation 79/10,s. 50. Skin and Wound Care. Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,	Written notification	Residents with skin integrity issues including skin tars, rashes with pressure ulcers are assessed weekly. This assessment must be documented. On a few occasions this documentation has missing.	We continue to regularly audit our documentation to ensure completion and reinstruct nurses as required.
The Licensee has failed to comply with O.Reg 79/10, s.91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O.Reg.79/10,s.91	Written Notification	Housekeeping cart housing cleaning products was not locked. The cleaning cart was unattended for a period greater than 5 minutes and located in an area where residents could potentially access the cart.	The staff member was reminded of the importance of keeping cart locked. Random checks occur with housekeeping staff to ensure this practice is maintained.
Licensee failed to comply with Long Term Care Act, c.8, s. 6 Plan of Care. Specifically failed to comply with the following: 1.Every licensee of a LTC Home shall ensure that there is a written plan of care for each resident that sets out, a. the planned care for the resident, b. the goals the care is intended to achieve; and c. clear directions to staff and others who provide direct care to the resident. 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	Written Notification	A resident with a partial bed rail in use did not have supporting documentation to support the need for a bed rail. The resident plan of care indicated a resident had altered skin care however the skin issue had healed and the care set out in the plan was no longer needed. Another resident who was assessed for a personal aid received it however the care plan did not	All of these items were resolved prior to the inspectors leaving the building. The resolution involved: - Providing education to staff on the importance of documenting every aspect of the residents care.

met, (b) the resident's care needs change or care set out in the plan is no longer necessary (c) care set out in the plan has not been effective.		reflect that the new aid had arrived and was being used by the resident. It was not communicated to staff who works with resident.	
Licensee has failed to comply with O. Reg 79/10,s.8.Policies, etc to be followed, and records.	Written Notification	The Fall's Risk Assessment documentation was not completed as indicated in the Home's policy. (Required for 3 consecutive shifts following a fall without injury and for 6 consecutive shifts following a fall with injury). The inspector found that on one occasion, the staff did complete follow up assessment on the Resident's health care record the 6th shift of 6 on when the resident sustain a fall with injury. The Home's Skin and Wound policy indicated that the Registered Dietitian and Physiotherapy would be notified of any new pressure ulcer of stage II or greater. This did not occur on one occasion.	Staff were reminded of policy.
Licensee has failed to comply with O. Reg 79/10, s. 35. Foot care and nail care	Written Notification	The inspector observed a resident to have long finger nails.	This practice is regularly audited.
Licensee has failed to comply with O. Reg 79/10, s. 37. Personal items and personal aids.	Written Notification	The inspector identified that a hearing aid did not have the resident name labelled on it.	It was labelled.
The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program.	Written Notification	It was identified that there was not an immunization tracking system in place for Visiting Therapy Dogs through St. John's Ambulance.	All volunteers bringing their dog in to provide pet visits for our residents are required to provide evidence of annual immunization. Our Volunteer Coordinator tracks this information to ensure we are compliant.