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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 3, 2015	2015_293554_0002	O-001153-14	Critical Incident System

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 23, and January 26-28, 2015

Log #O-001153-14 completed concurrently with Complaint Inspections relating to Log(s): #O-001183-14, O-001251-14, O-001424-14, and O-001440-14

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Associate Director of Care, Resident Services Coordinator, Registered Dietitian, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Activation Aide(s), Ward Clerk/Scheduler, Dietary Aide(s), Resident(s), and Families

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. Relating to Log #O-001440-14, for Resident #02:

The licensee failed to comply with LTCHA, 2007, s. 6 (5), by ensuring resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #02 has a history of cognition impairment.

A review of progress notes, for Resident #02, for a six month period indicated the following:

- Resident #02 was admitted to home accompanied by Family #53. The home was advised by Family #53 that Resident #02's Power of Attorney (Family #54 - POA) was in poor health and that the Acting POA was Family #51.

- Several progress notes, for a period of time, indicated the staff of the home contacted Family #53 to inform him/her of changes in resident's health care and or condition, medication changes and upcoming appointments. Entries in progress notes during this period indicate Family #53 as being the POA, despite family member telling the home he/she was not the POA during the admission.

- Progress note, on a specific date, indicated Family #51 (Acting POA) contacted the home to inform them that Family #54 (POA) was unavailable due to poor health. Family #51 informed the home that legal documents relating to Power Attorney were being faxed to the home as they spoke. (Note: Power of Attorney documents (dated approximately 4 years earlier), indicated Family #54 as the POA, and if unable to fulfil duties Family #51 is indicated as being the POA)

- Progress note, on a specific date four months post admission (written by Director of Care), indicated Family #51 (POA) contacted the home and requested that Family #53 was not to take Resident #02 to medical appointments, as Family #51 would accompany resident to all appointments.

- Progress notes, during the next month indicate the home continued to communicate resident's health condition and or changes in plan of care to Family #53, despite family

not being the POA.

Family #51 (POA) indicated providing the Power of Attorney legal documentation to the home during the early summer; family indicated paperwork was faxed to a registered nursing staff. Family #51 indicated the Director of Care indicated not receiving POA legal documents, at which time the home was provided a second copy of Power of Attorney for Care.

Family #51 indicated that despite the home being aware of who Resident #02's POA was they continued to share information with Family #53 and continued to allow family to take resident out to appointments without his/her consent. Family #51 indicated not being kept up to date with Resident #02's health status as information was being told to Family #53 and not him/her.

Director of Care indicated during an interview that he/she was unaware of who the Power Attorney was for Resident #02, despite the home's electronic health record indicating POA was Family #51, progress note entries and verbal communications with staff and Family #53 on admission indicating he/she was not POA.

Executive Director indicated being unsure of when legal documentation regarding Power of Attorney for Personal Care (for Resident #02) was presented by Family #51, but did indicated proper POA documents for Resident #02 is on file as of this time.

The Director of Care and the Executive Director both indicated that the home's practice is to share Personal Health Information with only the Power of Attorney (unless otherwise directed) and to follow the requests/wishes of POA.

Executive Director indicated that this situation has been a learning experience and changes will be made to ensure proper documents are on file for all residents on admission.[s. 6. (5)]

2. Related to Log #O-001251-14, for Resident #04:

The licensee failed to comply with LTCHA, 2007, s. 6 (7), by ensuring the care set out in the plan of care is provided to the resident as specified in the plan, specific to assistance during meal times.

According to the clinical health record, Resident #04 requires assistance with activities of

daily living.

A review of the plan of care indicated the following:

- Nutritional Risk, moderate risk due to responsive behaviours issues, cognitive impairment and resident leaves greater than 25% of meals uneaten. Goals of care included, to maintain weight. Interventions include, needs one to one assistance at meals; e.g. cueing, food cut up, reminders to eat; consider moving resident to feeding section, resident can feed self slowly but needs one to one assistance to eat and drink fluids; redirect if resident attempts to get up to leave dining room; encourage assorted dessert like tart and cookies etc., if refuses dessert offer ice cream at lunch and supper.

MDS Quarterly Assessment, written by Nutritional Care Manager, indicated resident's weight was down again this month. Resident #04's weight record indicated resident being below goal weight; RD indicated that resident's weight loss was undesirable.

The following observations were made during this inspection:

- January 26, 2015 – breakfast meal, at approximately 08:40 hrs, Resident #04 observed sitting at table with two glasses of orange juice and a plate of toast with peanut butter; resident using spoon to obtain orange juice from cup to drink, using fork to lift a ½ slice of toast from plate; observed reaching for food off co-residents plate. Resident #04 drank a glass of orange juice and ½ slice of toast and peanut butter during this meal observation; resident left dining room and wandered into hall at approximately 09:00 hrs. No staff provided one to one assistance to resident during this meal service nor redirected resident back to dining room table once resident began to wander.

- January 27, 2015 – breakfast meal, at approximately 08:35 hrs, Resident #04 observed sitting at table with two glasses of orange juice, two half pieces of toast with peanut butter and an egg; resident observed using spoon to obtain orange juice from cup to drink and using fork to eat slice of toast and peanut butter. Resident eventually lifted cup of juice and drank it. Resident ate two ½ slices of toast, but no egg before rising from the dining room table and then began wandering table to table. No staff provided one to one assistance to resident during this meal observation nor redirected resident back to dining room table once resident began to wander.

- January 27, 2015 – lunch meal, at approximately 12:05 hrs, Resident #04 observed sitting at the table with a glass of orange juice and a bowl of soup; resident observed

using a spoon to obtain orange juice from cup to drink. Resident sat with a bowl of soup in front of him/her until 12:15 hrs, when staff approached him and attempted to assist resident with soup (staff stood over resident versus sitting); resident refused staff's assistance, staff left at attempting twice to assist resident. Staff then placed a plate of sandwiches in front of resident, sandwiches sat in front of resident for approximately ten minutes before staff approached to encourage resident to eat; resident ate ¼ sandwich, and during this time co-resident sitting to the right of resident ate resident's other two quarter sandwiches. No dessert was offered to resident during this meal services, nor was one to one assistance provided to Resident #04.

Personal Support Workers (PSW) #64 and #65 both indicated Resident #04 eats independently, if they are able to get resident to come into the dining room and remain seated. Registered Practical Nurse (RPN) #63 indicated that if Resident #04 wanders during meal time then finger foods would be provided, but it was difficult to monitor resident to ensure food provided was eaten; RPN #63 further indicated resident eats most meals independently and does not require physical assistance from staff.

Registered Dietitian (RD) indicated that Resident #04 was to be provided one to one assistance, which meant, one staff was to sit with resident and offer encouragement and or physical assistance at all meals; RD further commented that all residents were to be offered meals which included dessert. RD indicated that interventions had been offered to Resident #04 to encourage weight gain but that Family #56 had refused nutritional supplements or special snacks in the past, as family member (#56) wanted resident to have the same snack choices as other residents within the home.

Registered Dietitian, indicated meeting once again with Family #56 during this inspection, at which time, family agreed to trial a nutritional supplement in an effort to promote weight gain. [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 ensuring there is a process in place and monitored to ensure the resident, the Substitute Decision Maker(SDM), if any, and the designate of the resident/SDM been provided the opportunity to participate fully in the development and implementation of the plan of care; and to ensure the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. Related to Log # O-001183-14:

The licensee failed to comply with LTCHA, 2007, s. 8 (3), by ensuring there at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

The home's nursing schedules were reviewed for a six month period; the review concluded that there were twenty-eight (28) shifts in which a Registered Nurse was not on duty within the home.

The following shifts were not covered by a Registered Nurse, but covered instead by a Registered Practical Nurse, during the period indicated above:
- day shifts (07:00-15:00hrs) x 12
- evening shifts (15:00-23:00hrs) x 13

- night shifts (23:00-07:00hrs) x 3

Note: The shifts not being covered are not as a result of an emergency or a planned or extended leave of absence by a registered nurse. Therefore, the exceptions to the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff are not applicable as per O. Reg 79/10, s. 45. (1)(2)

The Ward Clerk, who is responsible for posting shift availability and or filling shift vacancies (e.g. sick calls) indicated that the Director of Care and or the Executive Director (also an RN) will routinely act as the RN in the building or be ON CALL if there is no RN scheduled or available. The Ward Clerk indicated no awareness of the home using Agency Staff for shift coverage.

During an interview the Director of Care indicated no awareness of shifts not being covered by a Registered Nurse; DOC indicated that the home has three full time RN's (one days, evenings and nights) and a pool of both part-time and casual registered nurses. DOC indicated no issues with retention or recruitment of registered nurses.

However, during a second interview the Director of Care indicated being aware of shifts not being filled with a Registered Nurse due to regular RN's being scheduled for vacation, being off due to requested time off and/or sick time. DOC indicated that the home does have a contract with a Nursing Agency, but the agency had not been contacted for any of the above shifts as the agency is usually not able to provide coverage.

The Executive Director indicated the home no longer has a contract with the community based nursing agency, but instead the home's corporate office has their own nursing pool to draw from; Executive Director indicated that registered nurses, within the corporate staffing pool are rarely available due to being booked elsewhere and were not contacted to fill any of the above noted shift vacancies. The Executive Director indicated that an RN was hired in December and since the home is having no difficulty with 24/7 RN coverage that he/she is aware of.

The Executive Director indicated that the home's normal practice has been is to fill vacant Registered Nurse shifts with Registered Practical Nurse's and to have the Director of Care be On Call for any emergencies. [s. 8. (3)]

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 ensuring there is a process in place and monitored to ensure there at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Log # O-001153-14, for Resident #01:

The licensee failed to comply with O. Reg. 79/10, s. 107 (3) , by ensuring that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

A Critical Incident Report was submitted by the Associate Director of Care for an incident that occurred a week earlier.

Details of the incident are as follows:

- Resident #01 was found by staff sleeping in his/her roommate's bed. When staff roused resident in an attempt to redirected his/her own bed, Resident #01 complained of pain on movement. Resident was assessed by the charge nurse with no visible injuries, and given analgesic. The physician, for the resident, was contacted and instructed to monitor overnight and contact him/her if change in status. MD assessed the next evening and gave direction to transfer Resident #01 to hospital for assessment. Resident was admitted to hospital for treatment.

Progress notes, for Resident #01, reviewed for a one week period indicated the home was aware resident sustained injury and underwent treatment. Communications regarding the injury was via communications with both the family and resident's attending physician.

The Director of Care indicated that the Management Team was out of the home during the incident but the ON CALL Manager would have contacted CIATT as to the incident, prior to the home submitting the CIR.

A representative from the, Centralized Intake Assessment Triage Team (CIATT) confirmed by email on January 28, 2015, that the home did not contact MOH after-hours # nor did the home submit a CIR regarding the incident until one week post incident.

The Executive Director was unaware that the home did not contact the MOH's after-hours # as to the incident occurring. [s. 107. (3) 4.]

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Issued on this 3rd day of March, 2015

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

Original report signed by the inspector.