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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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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 22, 2016	2016_461552_0016	008325-16	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

MARIA FRANCIS-ALLEN (552), BAIYE OROCK (624)

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): June 28, 29, 30, July 5, 6, 7 & 8th, 2016

Critical Incident logs #028826-15, 012848-16 and #008325-16 related to allegation of neglect, #010884-16 related to falls

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), family members and residents

Also observed staff to resident interaction during provision of care, reviewed resident clinical health records and the home's policies on abuse and falls

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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. (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. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan

Regarding log #028826-15

A Critical Incident Report (CIR) was submitted by the home indicating that on the same day, the registered staff reported resident #002 was found with his/her linen stained and soaked. This was reported to the registered staff by PSW #110.
Review of the home's investigation documents indicated PSW #115 reported she provided care for the resident at two different times on that particular shift.

Review of the clinical health records indicated the resident was admitted to the home with several medical diagnosis including cognitive impairment. The RAI MDS assessment indicated the resident requires extensive assistance with 1 staff for bed mobility, toileting and transfer.

Review of the care plan related to toileting provided strategies for resident to be kept clean dry and odor free and included placing an incontinent device within resident's reach and 2 hour toileting during a specific time of the day.

During an interview with the RPN #113 she confirmed PSW #110 reported to her at the beginning of the shift that resident #002 was laying in bed, the incontinent product was opened and dry but his/her bed linen was stained and soaked.

During an interview PSW #110 explained that it was at the beginning of the shift that resident #002 was found laying in urine stained and soaked linen. PSW #110 and #112, both explained the resident is incontinent and requires extensive assistance with toileting. They further indicated the resident will often remove the incontinent brief and void all over the bed.

During an interview with the Director of Care (DOC) she confirmed the resident was left soaked in urine by staff and that based on the investigation, found the staff did not change the resident during his/her rounds. DOC explained it is the home's expectation that residents are toileted and agreed that the staff did not provide care as specified in the plan of care.

Regarding log #008325-16

A CIR was submitted by the home on an identified date indicating that two days earlier a report was received indicating resident #001 had reported being wet at a specific time but was not changed until fifty minutes later.

Review of care plan indicated the resident has urinary device which sometimes leaks or accidentally disconnects. The resident requires assistance from 2 to 3 staff members for transfers using a mechanical lift

Interview with resident #001 who explained he/she had been having some challenges with the urinary device. On this particular day the device leaked and his/her clothes got wet. The resident's family member saw that the clothing was wet and was upset that the resident had been sitting in wet clothes. It was reported to the charge nurse - eventually the staff came to change the resident but it took them a while to do so.

Interview with RN #100 who was present on the identified date - PSW #105 reported to staff member the resident's clothes was wet. The staff member found the urinary device was disconnected and she reconnected the device. The RN further indicated she told the resident his/her clothes would have to be changed. This occurred at shift change - reported this to oncoming staff and asked them to change the resident when shift report was completed.

During an interview with the DOC on July 6, 2016 she explained the staff did not provide the care as set out in the plan of care in that the staff was aware the resident's urinary device had leaked and they did not provide assistance to the resident until 50 minutes later. [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 to ensure the care set out in the plan of care if provided to residents as specified in the plan, to be implemented voluntarily, 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 failed to comply with is Policy related to falls prevention and Safety in the Shower room.

Ont. Reg 79/10 r.48 (1) 1 "every licensee of a long tern care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. a fall prevention and management program to reduce the incidence of falls and the risk of injury".

According to the Licensee's policy entitled "Bath Lifts, Tub chairs and Shower Commodes - LTC-K-80", "Seatbelts/protective bar will be applied at all times while the resident is sitting in the bathing chair. Brakes will be engaged during the lifting, lowering and transferring process."

Related to log #010884-16

Resident #009 was admitted to the home on an identified date with a several medical diagnosis including cognitive impairment. According to the resident's Falls Risk assessment completed the resident was assessed as being at high risk of falls related to medical condition, cognitive status and number of prescribed medications. There was however no noted incident of falls documented within the last 12 months.

On an identified date, the resident fell and sustained an injury during the provision of care by PSW # 120. Upon investigation it was found that the resident fell out of a chair because PSW #120 had not applied the seat belt.

In an interview with PSW # 120, she confirmed that she had not followed the policy to have the seat belt attached while the resident was in the chair. [s. 8. (1) (a),s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with it's "Resident Non-Abuse - Ontario, Index:LP-C-20-ON" Policy.

According to the The Licensee's Policy entitled "Resident Non-Abuse - Ontario, Index:LP-C-20-ON" with effective date of September 2001 and lastly reviewed on September 2014, it states under mandatory reporting:

"1. Any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report the suspicion and the information upon which it is based to the Executive Director (ED) of the Home or if unavailable, to the most senior supervisor on shift at that time. The person reporting the abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately,
2. The incident must be reported by staff following the Adverse Event Algorithm (LP-C-40 Appendix A)"

The Algorithm indicates that front line staff are to contact the ED or designate with all adverse events.

Related to log #012848-16

On an identified date, resident #004's family member approached RPN # 113 with allegations of abuse. He/she stated PSW #120 who came to assist the resident was very rough and the PSW just swung the resident's legs around with no warning and very fast. This allegation of abuse was not reported to the ED or designate by the RPN as specified in the Home`s policy.

In an interview with RPN #113, she explained the expectation of the home is when there is an allegation of abuse, she is to report that allegation to the Charge nurse, who

in turn, is supposed to call the ED or designate (Manager on-call) immediately. According to RPN #113, when the incident occurred, she was off her shift and she had reported to RPN #119 who was the charge nurse and that together they had spoken to PSW #120 about the incident.
PSW # 120, in an interview revealed that after having spoken to both RPNs on the day of the incident, she had to work in pairs with another PSW when providing care to the resident.

A review of resident # 004's progress notes did not reveal any documentation of the incident. In an interview with the ED , she confirmed the RPNs did not follow the policy when they failed to report immediately to her or the designate and that she only became aware of the incident after receiving an email from resident #004's family member the next day. [s. 20. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(ii) names of any staff members or other persons who were present at or discovered the incident

Regarding log #028826-15

A CIR was submitted by the home on an identified date indicating at the beginning of the shift, PSW #110 reported to the registered staff resident #002 was found with his/her linen soaked in urine and the incontinent brief was dry.

During the review of the CIR, the name of the night staff responsible for providing care to the resident was not indicated.

In an interview with the DOC, she acknowledged the CIR did not contain the names of all the staff members involved in this incident. [s. 104. (1) 2.]

Issued on this 22nd day of July, 2016

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

Original report signed by the inspector.