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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 20, 2017	2017_555506_0018	020286-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

BURLOAK
5959 NEW STREET BURLINGTON ON L7L 6W5

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

LESLEY EDWARDS (506), PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 23, 24, 25, 28, 29, 30, 31 and September 1, 2017.

During this inspection the following inspections listed below were conducted concurrently:

Complaints

010957-17- related to abuse and neglect and staffing
010957-17- related to staffing, skin and wound and pain management
012622-17- skin and wound, abuse and neglect, toileting and plan of care

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Staff Educator, Resident Assessment Instrument Co-ordinator (RAI), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents and families.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, observed medication passes, reviewed clinical records, policies and procedures, the home's complaints process, investigative notes and conducted interviews.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
5 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. (10) 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 met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Resident #005 was not reassessed and their plan of care was not reviewed or revised when the resident's care needs changed in relation to continence.
Minimum Data Set (MDS) coding completed on an identified dates in March and June 2017, indicated the resident's continence had deteriorated.
RAI co-ordinator #102 confirmed that the resident's continence had deteriorated as evidenced by the MDS coding completed on an identified date in June 2017, confirmed that resident #005's care needs related to continence had not been reassessed and the plan of care had not been reviewed or revised when it was documented that the resident's care need related to continence had changed. [s. 6. (10) (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 when the resident's care needs change the plan of care is reviewed and revised, 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 ensure 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, is complied with.

In accordance with O. Reg. 79/10, s. 48 and O. Reg. 79/10, r. 48. (3) the licensee is required to develop and implement an organized program of continence care and bowel management that included relevant policies, procedures and protocols.

The DOC provided a procedure titled "Continence Care-Change of Continence", identified as CARE2-010-01 with a review date of July 31, 2016. This procedure indicated the nurse will:
-Initiate a 3-Day Continence Diary with the change in continence status. If based on the nurse's clinical judgement it is determined not to complete a 3-Day Continence Dairy, the rational will be documented in the interdisciplinary progress note and continence assessment.

RAI Coordinator #102 and clinical documentation confirmed the above noted procedure was not complied with when MDS coding completed on an identified date in June 2017, indicated resident #005's continence had deteriorated and staff did not initiate a 3-Day Continence Diary, interdisciplinary progress note and did not complete a continence assessment. [s. 8. (1) (b)]

2. The Licensee failed to ensure 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, is complied with.

In accordance with O. Reg. 79/10, s. 48 and O. Reg. 79/10, r. 48. (4) the licensee is required to develop and implement an organized program of continence care and bowel management that included relevant policies, procedures and protocols.

The home had a procedure, "Pain assessment and Management, in the Care Manual, index number: CARE 8-010.02, effective date August 31, 2016". which identified: i. That when new regular pain medication is ordered and when there is a dosage increase or decrease of pain medication that the staff will initiate a pain monitoring tool for 72 hours.

A review of the clinical record for resident #010 noted that on two occasions once in February and once in March 2017, that the resident's pain medication was changed. In February 2017 a new pain medication was added and in March 2017 the dosage of the resident's pain medication was increased. A 72 hour monitoring tool was not initiated following either of these changes in resident #010's pain medication. ADOC #110 confirmed that this had not been completed as per the home's pain policy. [s. 8. (1) (b)]

3. The Licensee failed to ensure 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, is complied with.

In accordance with O. Reg. 79/10, s. 114(2) the licensee shall ensure that written policies and protocols are developed for the medication management system.
The home provided the licensee's policy "LTC Medication Incidents", identified as CARE13-030.10, last reviewed on August 28, 2016 which directed:
a) "For all Resident-related medication incidents, there will be a brief factual description of the incident, treatment and interventions documented in the interdisciplinary progress notes.

i) Staff did not comply with this direction when clinical records, specifically the interdisciplinary progress notes did not contain the information required in the above noted policy for a medication incident that involved resident #024 on an identified date in May 2017.
ii) Staff did not comply with this direction when clinical records, specifically the interdisciplinary progress notes did not contain the information required in the above

noted policy for a medication incident that involved resident #026 on an identified date in May 2017.

b) "The physician/Nurse Practitioner/Substitute Decision Maker/family will be informed of all Resident-related incidents. The Nurse will determine whether the Physician/Nurse Practitioner/Substitute Decision Maker/family requires notification immediately, within the next 12 hours or at the next visit".

i) Staff did not comply with this direction when clinical documentation and a Medication Incident Report (MIR) for resident #024 did not contain documentation that the resident's physician or Substitute Decision Maker (SDM) were notified of a medication incident. The medication incident occurred on an identified date in May 2017 when staff failed to administer a regularly scheduled medication to the resident.

ii) Staff did not comply with this direction when clinical documentation and a Medication Incident Report (MIR) for resident #026 did not contain documentation that the resident's physician or Substitute Decision Maker (SDM) were notified of a medication incident. The medication incident occurred on an identified date in May 2017 when staff failed to administer a regularly scheduled medication to the resident.

The DOC confirmed that it was the expectation that when notification of a medication incident was made to the resident's physician or SDM this would be documented on the MIR and in the interdisciplinary progress notes for each resident. [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 policies are followed regarding continence, pain and medication management, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, not reassessed at least weekly by a member of registered nursing staff.

Resident #010 had an identified pressure area on an identified date in December 2016. Documentation in the progress notes identified the pressure area as worsening on an identified date in January 2017. A review of the clinical record confirmed that the resident had not received a weekly skin assessment since an identified date in December 2016. ADOC #110 confirmed that the pressure ulcer was not reassessed at least weekly by the registered nursing staff during this period and the pressure area worsened. [s. 50. (2) (b) (iv)]

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 residents who exhibit altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee did not comply with the conditions to which the licensee was subject as outlined in section 4.1 Schedule C of the Long-Term Care home Service accountability agreement (LSAA) with the Local Health System Integration Act, 2006, which reads, "The Health Service provider shall use the funding allocated for an envelope for the use set out in Applicable policy". The Long-Term Care Homes Nursing and Personal (NPC) Envelope Section 1. b) reads, "direct nursing and personal care includes the following activities: assistance with the activities of daily living including personal hygiene services, administration of medication, and nursing care".

On an identified date in August 2017, PSW #108 was observed bringing the residents personal laundry back to the unit from the laundry room and observed completing laundry duties (delivering personal laundry to residents rooms). PSW #108 verified that the delivery of personal laundry was a regularly assigned duty to the nursing staff. The DOC and ED confirmed that this was a daily assigned nursing duty. [s. 101. (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 the licensee complies with conditions of LSAA agreement and ensures nursing staff are completing direct nursing duties, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, and the resident's physician/prescriber of the drug.

The DOC confirmed that if the required notification of a medication incident involving a resident was not documented on the Medication Incident Report (MIR) or in the resident's clinical record then the notification had not occurred.

a. On an identified date in May 2017, staff documented on a MIR that staff had not administered a regularly scheduled medication. The MIR provided an opportunity for staff to document if they had notified the resident, the resident's physician and/or the family/SDM. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.

b. On an identified date in May 2017, staff documented on a MIR that staff had not administered a regularly scheduled medication. The MIR provided an opportunity for staff to document if they had notified the resident, the resident's physician and/or the family/SDM. Documentation on the MIR indicated that none of the above noted individuals had been notified of this medication incident. A review of the resident's clinical record confirmed that there was no documentation on the date of the medication incident or following the medication incident that any of the above noted individuals had been notified of the medication incident.
The licensee failed to notify resident #024's and resident #026's physician and SDM that a medication incident had occurred for both of these residents on an identified date in May 2017. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, and the resident's physician/prescriber of the drug, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #003 was observed using a device on two identified dates in August 2017 which limited the resident's movement. A review of the clinical record confirmed there was no assessment completed to determine the reason for the use of the device, nor any documented consents or approvals for its use. RPN #104 and the RAI Coordinator #101 confirmed that the resident was not assessed to determine if the device was used as a PASD or a restraint nor did they have a documented consent or approval for the device in place. [s. 33. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriated to the risk level of the drugs.

Resident #010 was experiencing worsening symptoms and the physician changed the resident's medications on an identified date in February 2017. A review of the clinical record confirmed that staff did not monitor or document the resident's response to the new medication or the effectiveness of the medication related to their symptoms and this was confirmed with the RAI co-ordinator #117 on an identified date in August 2017. [s. 134. (a)]

Issued on this 29th day of September, 2017

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

Original report signed by the inspector.