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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
May 22, 2014	2014_284545_0009	O-000231-14 X O-000232-14	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

MONTFORT
705 Montreal Road, OTTAWA, ON, K1K-0M9

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

ANGELE ALBERT-RITCHIE (545)

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): April 1 and 2, 2014

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Care (DOC), Assistant Director of Care (A-DOC), Documentation Manager/RAI Coordinator, Activity & Volunteer Coordinator, Nurse Program Manager, Resident Service Coordinator, a Registered Nurse (RN), a Registered Practical Nurse (RPN) and two Personal Care Workers (PSW), family members and Resident #1.

During the course of the inspection, the inspector(s) reviewed health records for Resident #1 and Resident #2, Management of Narcotic and Controlled Drugs Policy Index LTC-F-80 (revised August 2012), Dementia Care Policy Index LTC-E-100 (revised August 2012), observed a registered staff prepare a mock administration and documentation of narcotic drugs, watched part of a video of a specific date in March 2014 focused on a specific hallway on a specific unit and observed care and services given to residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The Licensee failed to comply with O.Reg s. 53 (4) (b) in that the home did not ensure that strategies were developed and implemented to respond to Resident #1's behaviour such as his/her fear of the mechanical lift used for all transfers to the point of causing Resident #1 nausea and increased anxiety; and that the home did not ensure that actions were taken to respond to Resident #1’s needs, including reassessments and interventions and that Resident #1's responses to interventions were documented.

In a review of Resident #1’s health record, it was indicated that Resident #1 was admitted to the home on a specific date in March 2014 with several medical conditions, including a dementia type condition and a specific mood disorder. Resident #1 was taking a medication daily to help manage the mood disorder. On admission, the 24-hour care plan indicated that Resident #1 had a fear of mechanical lifts to the point of causing nausea and that one specific mechanical lift was to be used for transfers to and from bed and chair and that a different specific lift was to be used for transfers to and from the toilet.

On a specific date in March 2014 in a progress note by the physiotherapist, it was indicated that mechanical lifts were to be used for all transfers due to Resident #1's inability to walk or change position such as pivoting when standing up on his/her legs. Resident #1 qualified for a sit-to-stand lift as he/she was able to stand with support and had good strength in his/her arms.

In a review of the plan of care dated on a specific date in March 2014, it was indicated that Resident #1 “did not accept use of mechanical lift, preferring a 2-person transfer but due to decreased mobility, a 2-person transfer was not possible”. Interventions in the plan of care directed staff to use a mechanical lift for all transfers with 2 persons, to guide Resident #1 during transfer by verbally explaining each step, to follow physiotherapy recommendations and to ensure Resident #1 had call bell by him/her at all times and to remind Resident #1 to use it. The plan of care did not provide strategies on how to manage Resident #1’s fears and behaviour.

On a specific date in April 2014 Inspector #545 observed PSW #S100 and PSW #S101 transfer Resident #1 from toilet to his/her own personal recliner chair using a sit-to-stand mechanical lift. The transfer was conducted slowly; staff talked to Resident #1 throughout the transfer explaining each step. The mechanical lift was raised to a minimum height. Resident #1 exhibited tension as evidenced by facial expression

throughout the entire transfer. When asked how he/she felt about the mechanical lift, Resident #1 indicated that he/she hated being transferred by machines, was afraid but understood the need as his/her legs were no longer strong enough.

During an interview with PSW #S100 he/she indicated being aware that Resident #1 had been fearful of mechanical lifts since the admission to the home. PSW #S100 indicated that Resident #1 often tried to convince staff to do the transfer without the use of the mechanical lift. PSW #S100 indicated that Resident #1's mood changed whenever he/she saw the mechanical lift. PSW #S100 indicated that on a specific date in March 2014, Resident #1 became agitated and used abusive language when PSW #S100 entered the room with a specific mechanical lift to transfer Resident #1 with the assistance of PSW #S111 from the bed to the wheelchair.

During an interview with PSW #S101 he/she indicated that Resident #1 was afraid of mechanical lifts but that staff had to use the sit-to-stand mechanical lift to transfer Resident #1 to and from toilet and a different lift to and from the bed to the wheelchair.

During an interview with the DOC on a specific date in April 2014 she indicated that Resident #1's fears regarding the use of mechanical lifts to the point of causing nausea had been identified on admission but no strategies had been implemented or documented in the plan of care until a specific date in April 2014. The DOC indicated that she had updated the plan of care on a specific date in April 2014 to include that "Resident #1 had a fear of mechanical lift" and "directed staff to lift Resident #1 at minimum height when in lift". The DOC indicated that she consulted with the Behavioural Support Ontario (BSO) assigned staff in regards to Resident #1's responsive behaviour of anxiety secondary to the use of the mechanical lift. The DOC also indicated that strategies would be implemented to help reduce responsive behaviour of anxiety during all transfers with use of mechanical lifts.

As such Resident #1's plan of care prior to a specific date in April 2014 did not include strategies to respond to Resident #1's fear causing anxiety and nausea during all transfers with the use of mechanical lifts. [s. 53. (4) (b)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 131 (2) in that the home did not ensure that a specific narcotic was administered to Resident #2 in accordance with the directions for use specified by the prescriber.

In reviewing the physician orders from a specific date in March 2014 for Resident #2, it was indicated that a specific dose of a specific narcotic was to be given every 3 hours.

The medication administration record (MAR) indicated that the first dose of the narcotic was administered to Resident #2 at a specific time on a specific date in March 2014 and that a second dose was administered three hours later as per physician's order.

In a review of Resident #2's MAR and Individual Narcotic Count Sheet, a record of preparation and administration for the third dose on a specific date in March 2014 of the injectable narcotic, was not found.

During an interview with the Director of Care on a specific date in April 2014, she indicated that when she met with RN #S109 on a specific date in March and and on another specific date in April 2014, RN #S109 stated he/she administered two doses of the narcotic to Resident #2 during his/her shift on a specific date in March 2014.

The Director of Care indicated that Resident #2 was expected to receive the narcotic subcutaneously every 3 hours for palliative care; therefore three doses should have been administered the on a specific date in March 2014, on a specific eight hour shift.

As such, the home did not ensure that a specific narcotic was administered to Resident #2 every 3 hours as ordered by the prescriber, on a specific shift of a specific date in March 2014. [s. 131. (2)]

Issued on this 22nd day of May, 2014

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