Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2021	2021_818502_0004	012027-21, 012875-21, 012887-21, 013463-21	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

JULIENNE NGONLOGA (502), MANON NIGHBOR (755)

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): November 8, 9, 10 and 12, 2021.

The following intakes were completed during this Critical Incident System (CIS) inspection:
- log #013463-21 (CI #2886-000015-21) related to alleged resident to resident abuse,
- log # 012875-21 (CI #2886-000012-21) related to responsive behaviours, and
- log # 012887-21 (CI #2886-000013-21) and log # 012027-21 CI # 2886-000011-21 related to staff towards resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurse (RPN), Personal Support Workers (PSWs), Infection Prevention and Control (IPAC) Specialist, Recreation Manager, Residential Assessment Instrument (RAI) Manager / Behaviour Support Ontario (BSO) Specialist, Administrative Assistant (AA), and Residents.

During the course of the inspection, the inspector(s) observed resident and staff interactions and resident's environment; reviewed resident health care records, Medication Administration Records, Behavioural Support Ontario-Dementia Observation System (BSO-DOS), staff schedules, abuse’s policy and relevant home’s record.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
3 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	Légende 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 written plan of care set out clear directions to staff and others who provide direct care to the resident.

An identified resident has mild cognitive impairment. Progress notes for the identified period recorded that the resident displayed specified behaviours toward other cognitively impaired residents in the unit as followed:
- on an identified date and in separate occasions, the resident exhibited specified behaviours toward two identified residents. Staff documented that the resident continued to be focused on the identified resident while searching for their spouse.
- on another identified date, two identified residents exhibited specified behaviour in an identified care area. One of the two resident's behaviour worsen when staff intervene.

The resident's plan of care indicated that they like to socialize, but they need to be supervised in presence of others.

In separate interviews with BSO Program Lead and DOC, stated that on the day of the incident, a staff was assigned to monitor the hallways and redirect residents to ensure their safety.

A staff member, who was assigned to monitor the hallways and ensure safety of the residents, indicated that they informed other staff prior to leaving the unit. Another staff indicated that they were not aware that the hallways were unsupervised as the assigned staff did not inform them prior living the unit.

The hallways were unsupervised for an identified period, within that time frame, camera footage showed other staff going in and out residents’ room but did not check on the identified resident's room, resulting in the above identified residents engaging in specified behaviour in an identified home area.

The plan of care did not provide clear direction to assigned staff who were monitoring resident need to ensure that other staff were aware they were leaving for their break and to ensure that identified resident was monitored during this period.

Sources: Home’s investigation notes, identified resident’s RAI-MDS assessment, progress notes, care plan, CIS #2886-000015-21, interview with staff, BSO Program Lead, DOC. [s. 6. (1) (c)] (502)

2. 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.

An identified resident had severe cognitive impairment and they exhibited specified socially inappropriate behaviours.

The resident's current care plan directed staff, to monitor the resident closely due to the resident behaviours mentioned above.

In separate interviews with BSO Program Lead and DOC stated that on the day of the above identified incident, a staff was assigned to monitor the hallways and redirect residents to ensure their safety.

A staff member, who was assigned to monitor the hallways and ensure safety of the residents, indicated that they informed other staff prior to leaving the unit. Upon their return to the unit, staff did not see the resident wandering the unit, as per their normal routine. They inquired with other staff, and they were not aware of the resident's location until found in identified room. An identified staff member indicated that they were not aware that the hallways were unsupervised as the assigned staff did not inform them prior living the unit.

By leaving the hallway unsupervised, the above identified resident was not monitored closely, therefore not protected from above identified behaviour by another resident.

Sources: Identified resident's RAI-MDS assessment, progress notes, care plan, CIS

#2886-000015-21, interview with staff, BSO Program Lead and DOC. [s. 6. (7)] (502)

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 the written plan of care set out clear directions to staff and others who provide direct care to the resident, and that 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 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 has failed to ensure that the residents' responses to responsive behaviour interventions were documented in the licensee’s Behavioural Supports Ontario-Dementia Observation System-Data Collection Worksheet (BSO-DOS).

Progress notes for identified period, recorded that an identified resident was constantly displaying specified behaviours in identified care areas. The resident was totally unable to understand direction. The resident was to be monitored closely and BSO-DOS worksheet was initiated of the monitoring. The worksheets have 3 steps to be completed as part of the monitoring.

Review of two BSO-DOS worksheets for the resident did not identify the start or the end date of the monitoring. Step 1 and step 3 were left blank. Step 2 of the three identified steps on the worksheet was incomplete on multiple day, evening and night shifts for the above identified period.

In an interview with Inspector #755, BSO Program Lead verified that documentation of the resident's responses to the interventions should have been completed at each shift and analyzed the weekly data collected.

Sources:
The resident's Progress notes and BSO-DOS Worksheet Interview with the BSO Program Lead. [s. 53. (4) (c)] (502)

2. Review of progress notes showed that on an identified date and in two separate occasions, an identified resident exhibited specified behaviour toward tow identified residents. On another identified date resident exhibited specified behaviour toward a third identified resident.

Staff were to monitor the identified resident and redirect them to their room when they start to exhibit the above identified behaviours. BSO-DOS worksheet of the monitoring was initiated after each incident above identified.

Review of the resident’s BSO-DOS worksheet initiated for identified periods, showed Step 2 of the three identified steps on the worksheet was incomplete on multiple day, evening and night shifts for the above identified period. Further review showed that BSO Lead noted that the worksheet was incomplete before signing the BSO-DOS worksheet.

In an interview with Inspector #755, BSO Program Lead verified that documentation of the resident's responses to the interventions should have been completed at each shift and analyzed the weekly data collected.

Sources:
The resident's Progress notes and BSO-DOS Worksheet.
Interview with the BSO Program Lead. [s. 53. (4) (c)] (502)

3. Two identified residents had cognitive impairment, and one of the resident had a history of specified behaviours.

On an identified date, it was reported that an identified resident exhibited specified behaviour toward another identified resident. A BSO-DOS Worksheet and one to one surveillance (1:1) interventions for the identified resident's responsive behaviours were initiated. The Behaviour Progress Notes were reviewed for an identified period.

-On identified dates it was documented that BSO-DOS and 1:1 interventions were in place. No further documentation related to the BSO-DOS was found in the Behaviour Progress Notes. The BSO_DOS is no longer in place and the Executive Director said that the 1:1 monitoring would continue.

- In an interview, the BSO Program Lead confirmed that three BSO-DOS Worksheets above initiated were incomplete. The Worksheet was a two-sided form, step #1 and #3 is on one side and step #2 was on the other side. The Worksheets initiated on another period were only one-sided copies and only included step #2. The three Worksheets, Step #1 and #3 were blank.

The BSO-DOS, step two documentation was missing from the following worksheets on multiple day, evening, and night shifts for the above identified period. BSO Program Lead verified that the BSO-DOS Worksheets described above were incomplete.

Sources:
Interview with the BSO Program Lead. The resident’s relevant clinical health records. BSO-DOS Soutien en cas de troubles du comportement en Ontario-Système d’observation de la démence. Guide de l’utilisateur. (Guide on how to complete the BSO-DOS Worksheet). [s. 53. (4) (c)] (755)

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 the actions taken to meet the needs of the resident with responsive behaviours include documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as it relates to the Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, “Just Clean Your Hands (JCYH)”

During identified meal service in a specified dining room, the inspector did not observe identified staff members assist identified residents clean their hands before meal as residents’ hands were not cleaned before entering the dining room for breakfast. Other residents were observed leaving the dining room without cleaning their hands.

One of the staff member were not aware about the procedure. The staff indicated the residents received morning care prior coming to the dining room.

As such, there was a potential risk to residents of being impacted by cross-contamination if their hands were unclean.

Sources: Direct observations of residents and staff. Review of The Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, “Just Clean Your Hands (JCYH)” and staff interviews. [s. 229. (4)] (502)

2. On an identified date and time, Inspector observed an identified resident and other residents leaving the dining room, on specified care area, after their meal, without washing or sanitizing their hands. The staff in the dining room were busy serving and feeding other residents and did not assist or remind the residents to clean their hands after their meal.

An identified resident said that staff always assisted residents to sanitize their hands with the bottle of alcohol-based hand sanitizer before meals but not afterwards. Another

identified resident shared that staff sometimes forgot to sanitize resident's hands, after meals.

As such, there was a potential risk to residents of being impacted by cross-contamination if their hands were unclean.

Sources
Inspectors observations and interviews with identified residents.
The Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program,
"Just Clean Your Hands (JCYH)" [s. 229. (4)] (755)

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 all staff participate in the implementation of the infection prevention and control program as it relates to the Hand Hygiene (HH) Program in accordance with the Ontario evidence based HH program, "Just Clean Your Hands (JCYH)", to be implemented voluntarily.

Issued on this 29th day of November, 2021

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

Original report signed by the inspector.