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
Apr 27, 2015	2015_363591_0002	T-1661-15	Resident Quality Inspection

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

ELGINWOOD
182 YORKLAND STREET RICHMOND HILL ON L4S 2M9

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

NATASHA JONES (591), JANET GROUX (606), VALERIE JOHNSTON (202)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 30, February 4, 5, 6, 7, 8, 10, 11, and 12, 2015.

The following Complaint Intake was inspected concurrently with this Resident Quality Inspection (RQI): T-262-15.

The following Critical Incident Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T-1599-14, T-533-14, and T-883-14.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), acting director of care (ADOC), acting assistant director of care (AADOC), dietary manager (DM), recreation manager (RM), environmental service manager (ESM), business manager (BM), registered dietitian (RD), registered staff, staffing coordinator, personal support workers (PSWs), housekeeping, residents, and family members of residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Sufficient Staffing

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

14 WN(s)
0 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 are kept confidential in accordance with the Act.

On an identified date, on an identified home area, the inspector observed the Point of Care (POC) documentation screen to be open and unlocked exposing resident health information, with no staff present. At 1:38 p.m., a PSW exited a resident's room and confirmed that the POC screen had been left unlocked exposing resident personal health information. [s. 3. (1) 11. iv.]

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A record review of the policy titled Medication Administration LTC-F-20 indicates all medication administered, refused or omitted will be documented immediately after administration on the medication administration record (MAR)/ treatment administration record (TAR) using the proper codes by the administering nurse.

A record review of the electronic medication administration record (e-mar) on an identified date revealed an identified resident's 7:30 a.m. dose of an identified medication, and 8:30 doses of 3 identified oral medications were documented as administered.

Observation on an identified date and time found the above mentioned medications still in the medication cart.

An interview with an identified registered staff confirmed the above mentioned resident had refused his/her medications and this should have been documented in the e-mar as refused.

An interview with the ADOC confirmed that staff failed to follow the home's policy. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Record review of an identified resident's written plan of care revealed that bed side rails should be used while the resident is in bed.

Observations of the resident revealed that 2 bed side rails were up while the resident was in bed.

Interviews with the ESM and the ED revealed that the beds in the home had not been evaluated, and confirmed that there were no records available to demonstrate that bed entrapment testing had been completed. [s. 15. (1) (a)]

2. Record review of an identified resident's written plan of care revealed that 2 quarter side rails should be up while the resident is in bed.

Record review revealed that the home did not complete a bed entrapment audit which identifies potential entrapment zones issues.

Interview with the ADOC confirmed that there were no records available to demonstrate that bed entrapment testing had been completed. [s. 15. (1) (a)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm is immediately reported to the director.

Record review of the written plan of care for an identified resident, directed staff to provide transferring assistance with the use of a walker and two staff present.

Staff interviews indicated that on an identified date, the resident became dizzy and requested to sit on the floor while being transferred from the bathroom to her bed. Staff indicated that they were not able to get the resident to the bed or chair nearby when she suddenly fell to the floor. An identified staff member indicated that she remained with the resident while a second identified staff member called an identified registered staff. The identified registered staff indicated in an interview that he/she assessed the resident, confirmed that the resident had no injuries and with the assistance of the first identified staff member, transferred the resident back to bed using a Hoyer mechanical lift. The progress notes indicated that on an identified date and time, the resident complained of severe pain and was sent to hospital for further assessment. The resident was later diagnosed with an identified injury and returned to the home on an identified date. On an identified date the resident's Power of Attorney (POA) reported to the director of care (DOC) and the ED that he/she suspected negligence of his/her mother. On an identified date the DOC contacted the police. An interview with the ED indicated that the home completed an investigation of the resident's fall on the specified date, with no evidence to support negligence.

The ED confirmed that the allegation of negligence or incompetent treatment of care resulting in risk or injury to the resident on an identified date, had not been reported to the Director. [s. 24. (1) 1.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

On an identified date and time, an identified resident was observed to be sitting in an identified chair. Interviews with identified staff revealed that the resident does not go to bed during the day and will remain in the chair all day. Staff indicated that they are unaware of the resident's sleep and rest patterns, however, will assist him/her to bed at an identified time.

A review of the above mentioned resident's plan of care did not indicate any sleep and rest patterns for the resident.

An interview with the ADOC confirmed that the sleep and rest patterns for the resident had not been assessed and included in his/her plan of care. [s. 26. (3) 21.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care.

An identified resident's plan of care identified him/her as using two quarter side rails raised while in bed as a personal assistive service device (PASD).

Staff interviews revealed that the resident is total care, has no upper body mobility and uses the side rails raised while in bed to prevent him/her from falling out of bed.

An interview with the ADOC indicated that the quarter side rails used on the resident's bed would be considered a restraint and confirmed that the use of the side rails had not been included in the resident's plan of care. [s. 31. (1)]

2. The licensee failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act that staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.

Review of an identified resident's plan of care indicated the resident as having two quarter side rails that are to be raised while the resident is in bed as a PASD.

Interviews with identified staff revealed that the resident is total care, has no upper body mobility and would not be able to use the side rails for repositioning. Staff indicated that the resident uses two quarter side rails raised while in bed to prevent him/her from falling out of bed.

An interview with the ADOC revealed that the quarter side rails used on the resident's bed would be considered a restraint as the resident would not be able to use the side rails to reposition himself/herself.

The ADOC confirmed that the use of the side rail restraint had not been ordered or approved by a physician or registered nurse in the extended class. [s. 31. (2) 4.]

WN #7: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee has failed to ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care.

On 2 identified dates and times, an identified resident was observed to be sitting in an identified chair with an identified device in place.

Interviews with identified staff revealed that the resident is to use the device while in his/her chair during meals and upon the resident's request as a PASD.

Record review of the resident's plan of care did not include the identified device a PASD.

Interviews with an identified registered staff and the ADOC confirmed that the use of the identified device as a PASD for the resident had not been included in the resident's plan of care. [s. 33. (3)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

The licensee failed to seek the advice of the Residents' Council and Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Record review and an interview with the Residents' Council and Family Council president revealed that the home sends out a yearly satisfaction survey. The Family Council president indicated that the home notified the council of when the satisfaction survey will be mailed out to residents and families and when the results are expected. However the advice of the council was not sought in the development and the carrying out of the survey.

An interview with the ED confirmed that the satisfaction survey is a standardized survey developed by a contracted third party organization and that residents and families were not consulted in the development and the carrying out of the survey. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Record review of the policy titled Resident Non-Abuse -Ontario LP-C-20-ON, revised September 2014, reveals the resident, and/or the resident's substitute decision maker (SDM) will be informed of the results of the investigation immediately upon the completion of the investigation.

Record review revealed that the home did not inform the SDM of the outcome of the abuse investigation that was reported on an identified date in which an identified resident reported that an identified staff member was rough with him/her during care.

An interview with the SDM of the above mentioned resident revealed the home did not contact him/her with the outcome of the investigation. [s. 97. (2)]

WN #10: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstance, the following incident in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Record review of the critical incident report revealed that the home was declared in enteric outbreak on April 3, 2014.

An interview with the ADOC confirmed that the home did not report the outbreak to the Director until April 11, 2014. [s. 107. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a resident is being restrained by a physical device under section 31 of the Act that the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

An identified resident's plan of care identified him/her as having two quarter side rails that are to be raised while the resident is in bed.

Interviews with identified staff revealed that the resident is total care, has no upper body mobility and would not be able to use the side rails for repositioning. Staff indicated that the resident uses two quarter side rails raised while in bed to prevent him/her from falling out of bed.

An interview with the ADOC indicated that the quarter side rails used on the resident's bed, would be considered a restraint as the resident would not be able to use the side rails reposition himself/herself.

An interview with the ADOC confirmed that because the use of the side rails is a restraint, the resident had not been monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff. [s. 110. (2) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies.

On an identified date, an identified registered staff was observed removing an identified resident's identified personal belonging from the table in the dining room and locking it in the medication cart.

Record review of the resident's care plan revealed that his/her identified personal belongings should be locked in the medication cart when not in use.

An interview with an identified registered staff member confirmed that resident's personal belongings are kept locked in the medication cart when not in use.

An interview with the DOC confirmed that resident personal items should not be stored in the medication cart and the medication cart was not used exclusively for drugs and drug related supplies. [s. 129. (1) (a) (i)]

WN #13: 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 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Findings/Faits saillants :

1.The licensee has failed to ensure that a member of the registered nursing staff may permit a nursing student to administer drugs to a resident if the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114.

Record review of the policy titled Orientation Program-Ontario LP-G-10-ON, effective date March 2012 revealed student placements are not included in the role specific orientation training for medication administration.

On an identified date, the inspector observed an identified student nurse administer medication to an identified resident under the supervision of an identified registered staff. Interviews with the student nurse and identified registered staff revealed that the student nurse had not been provided with training on the home's medication management system.

An interview with the AADOC confirmed that student placements are not provided training on the home's medication management system and that this is the responsibility of the school. [s. 131. (4.1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
3. The name, strength and quantity of the drug
4. The name of the place from which the drug is ordered
5. The name of the resident for whom the drug is prescribed, where applicable
6. The prescription number, where applicable
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home

Record review of policy titled Drug Record Book Procedure Number 2.4, revised July 2014, revealed that for ordering/receiving medication, the nurse is required to sign and date the entry to confirm the order/receipt of the medication.

Record review of a drug record book revealed that on page 21, there was no documentation for the order/receipt of the following medications: folic acid, vitamin D, calcium, aricept, lipitor, clotrimazole, betamethasone, nystatin, kefflex, betaderm, fentanyl patch, and immodium.

An interview with an identified registered staff confirmed that on page 21 of the drug record book, the above noted medications did not have signatures and dates of order/receipt. [s. 133.]

Issued on this 27th day of April, 2015

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

Original report signed by the inspector.