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
Nov 10, 2016	2016_360111_0023	013471-16	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

FENELON COURT
44 WYCHWOOD CRESCENT FENELON FALLS ON K0M 1N0

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

LYNDA BROWN (111), DENISE BROWN (626)

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): October 19-21, 24 & 25, 2016

During the course of the inspection, the inspector(s) toured the home, observed medication administration, reviewed resident health care records, and reviewed the following home's policies: Minimizing of Restraints and Infection Prevention and Control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Resident Council President, Family Council member, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

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:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

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).

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:
5. The restraining of the resident 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. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk [31.(2)2].

Observation of resident #10, #015 & #019 by Inspector #111, during stage one of the Resident Quality Inspection (RQI), indicated the use of specified bed rails in the up position when in bed.

Interview with RN #100 indicated resident # 015 & #019 used specified bed rails when in bed and used for safety

Interview with RN #105, RPN #101 & #102 were all aware resident #010, #015 & #019 used specified bed rails when in bed but unaware of whether the bed rails were used as a Personal Assisted Safety Device (PASD) or a restraint. All staff interviewed indicated an electronic assessment "Least Restraint Alternatives" was used for lap belt restraints but this assessment tool was not used for bed rails.

Interview with PSW #103 indicated resident #015 & #019 used specified bed rails when in bed, was unable to get out of bed on own, required two staff for repositioning when in bed and two staff assist with mechanical lift for all transfers. The PSW was unaware if the bed rails were a PASD or a restraint and indicated the use of the bed rails were not monitored when in use.

Interview of RPN #117 indicated resident #010 used specified bed rails for safety at resident request. Interview of PSW #104 indicated resident #010 used specified bed rails when in bed and are used as a restraint as the resident was unable to get out of bed on own.

Review of the current care plan for resident #010 indicated under bed mobility, required support as evidenced by inability to complete task on own, due to physical limitations and disease process. Interventions included: provide extensive assistance with bed mobility x2 staff, required specified bed rails for safety, and "See PASD focus for bed rails" Under risk for falls, indicated "put [specified bed] rails up at all times when in bed for safety with hourly checks- see restraint focus". There was no PASD or restraint focus in the written care plan.

Review of the current care plan for resident #015 & #019 indicated under bed mobility, inability to complete task on own due to impaired cognition. Interventions included: "requires sides to assist with mobility" and provide total assistance for bed mobility with 2 staff. Under risk for falls, indicated "put [specified bed rails] up at all times when in bed for safety with hourly checks- see restraint focus". There was no restraint focus identified in the written plan of care.

Therefore, interview with staff and review of the written plan of care indicated: resident #015 & #019 were unable to move in bed without staff assistance and unable to exit the bed without staff assistance, and the bed rails were used a restraint. For resident #010, the bed rails were used as a PASD (at resident request). There was no documented evidence that alternatives were tried prior to the implementation of the restraint or PASD. [s. 31. (2) 2.]

2. The licensee failed to ensure the restraint plan of care included an order by the physician or the registered nurse in the extended class [31.(2)4].

The specified bed rails used for resident #015 & #019 were used as a restraining device as the residents were unable to self transfer or reposition in bed, and there was no

physician or registered nurse in the extended class order in place. [s. 31. (2) 4.]

3. The licensee failed to ensure the plan of care related to restraint or PASD use included consent that was obtained by the residents, or the residents' SDM's when the bed rails were used either as a PASD or a restraint [31(2)5].

During stage 1 of the RQI, resident #010, #015 & #019 were identified as using specified bed rails in the up position when in bed.

Interview with RN #105, RPN #101 & #102 indicated they were all aware resident #010, #015 & #019 used specified bed rails when in bed but unaware of whether the bed rails were used as a PASD or a restraint. All staff confirmed no consent was obtained by the residents, or the residents' SDM's. [s. 31. (2) 5.]

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 when a restraint is used on any resident in the home, the restraint plan of care includes alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk, to be implemented voluntarily.

WN #2: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission, unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Review of the LTCH Licensee Confirmation Checklist Infection Prevention and Control indicated "no" under item #1, that each resident admitted to the home was screened for tuberculosis (TB) within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the results were available to the licensee.

Interview with the Administrator indicated the home's screening of TB is based on the Public Health direction, which included a chest x-ray completed prior to admission within the last year, or on admission. The Administrator indicated three residents were not screened for TB upon admission: resident # 021, 022, 023.

A review of new admissions in 2016 indicated:
-resident #013, admitted on a specified date had a physician order obtained on admission for TB screening. There was a chest x-ray (CXR) completed approximately one month after admission, which was not within 14 days after admission.
-resident #021, admitted on a specified date had a physician order obtained on

admission for TB screening, There was no documented evidence of SDM consent available and there was no indication the resident received a chest x-ray (CXR).
-resident #022, admitted on a specified date had a physician order obtained on admission for TB screening. There was a CXR completed a year prior to admission, which is greater than 90 days before admission.
-resident #026, admitted on a specified date had a physician order obtained on admission for TB screening. There was a CXR completed approximately a year prior to admission, which is greater than 90 days before admission.
-resident #023, #027, #028 and #029 were admitted on a specified date, had a physician order obtained on admission for TB screening. There was no documented evidence the residents received a chest x-ray(CXR).[s. 229. (10) 1.]

2. The licensee failed to ensure that residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

A list was provided by the home with all new admissions in 2016. A review of the residents health records was also completed and indicated:
-resident #013,#021, #022, #023, #026, #027, #028, and #029 were admitted on a specified date, a physician order was obtained on admission for immunizations (influenza, tetanus, diphtheria and pneumovax). There was no documented evidence the residents were offered the immunizations. [s. 229. (10) 3.]

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 staff participate in the implementation of the infection prevention and control program, specifically, to ensure that all new admissions are screened for tuberculosis at some time in the 90 days prior to admission, and offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident related to use of bed rails.

During stage 1 of the RQI, resident #019 was identified as using specified bed rails in the up position when in bed.

Interview with RN #105, RPN #101 & #102 were all aware resident #019 used specified bed rails when in bed but unaware of whether the bed rails were used as a PASD or a restraint.

Review of the current written care plan for resident #019 by Inspector #111, indicated under bed mobility, inability to complete task on own. Interventions included: requires "[specified bed] rails up for safety" and assist with mobility using two staff. There was no indication which bed rails were used (i.e.quarter, half, or full) and whether they were a restraint or a PASD.

Interview with PSW # 103 indicated resident #019 used specified bed rails when in bed, was unable to get out of bed on own, required two staff for repositioning when in bed and two staff assist with mechanical lift for all transfers. The PSW was unaware if the bed rails were a PASD or a restraint.

Therefore, the specified bed rails used for resident #019 were used as a restraining device as the resident was unable to self transfer or reposition in bed, and the plan of care did not provide clear direction to staff and others who provide direct care to the resident related to the use of bed rails. [s. 6. (1) (c)]

2. During stage 1 of the RQI, resident #010 was observed in bed with specified bed rails

in the up position.

Review of the current care plan for resident #010 indicated under bed mobility, required support as evidenced by inability to complete task on own, due to physical limitations and disease process. Interventions included: provide extensive assistance with bed mobility x2 staff, requires specified bed rails for safety, and "See PASD focus for bed rails, is able to assist with turning from side to side when in bed". Under risk for falls, indicated "put [specified bed rails] up at all times when in bed for safety with hourly checks- see restraint focus". There was no PASD or restraint focus in the care plan.

Interview of RPN #117 indicated resident #010 used specified bed rails for safety at resident request. Interview of PSW #104 indicated resident #010 used specified bed rails when in bed and were used as a restraint as the resident was unable to get out of bed on own.

Therefore, the plan of care did not set out clear directions to staff and others who provide care to the resident related to use of bed rails, whether they were being used as a PASD or a restraint. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident shower had at least two easily accessible grab bars, with one grab bar located on the same wall as the faucet and one grab bar located on the adjacent wall.

During the initial tour of the home by Inspector #626, there were 3 units noted in the home and each unit had 2 shower rooms in use. Observation of all shower rooms indicated there were no shower grab bars observed on the wall where the faucet was located. There was a grab bar on the adjacent wall in each of the shower stalls.

During an interview on October 19, 2016 by Inspector #626, with the Administrator, indicated that there were two grabs bars in the shower stalls. The Administrator also indicated that she was not aware of the legislation and believed that the current grabs bars were adequate. [s. 14.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is the resident-staff communication and response system available in every area accessible by residents.

During the initial tour of the home, on October 19, 2016, by Inspector #626, there was an enclosed court yard noted on each of the three units. Observation of each courtyard indicated there was no resident to staff communication and response system accessible. These areas were accessible by residents.

During an interview on October 19, 2016, by Inspector #626, the Administrator indicated that she was not aware that resident to staff communication and response system (call bells) were required in the court yards. [s. 17. (1) (e)]

Issued on this 16th day of November, 2016

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

Original report signed by the inspector.