Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
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Original Public Report

Report Issue Date October 12, 2022
Inspection Number 2022_1205_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Revera Long Term Care Inc

Long-Term Care Home and City
Forest Heights, Kitchener, Ontario

Lead Inspector
Kim Byberg #729

Additional Inspector(s)
Alicia Campbell #741126, Kristen Owen #741123, Amanpreet Malhi #741128

Inspector Digital Signature
Kimberly Byberg
Digitally signed by Kimberly Byberg
Date: 2022.10.17 09:14:13 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): September 1-2, 6-9, 19, 20, 2022. Off-site September 21, and 23, 2022.

The following intake(s) were inspected:

- Intake #014970-22, related to an emergency and unplanned evacuation;
- Intake #015329-22, and intake #008582-22, related to a fall causing a significant change in the residents' health status requiring transfer to the hospital;
- Intake #004509-22, related to allegation of staff to resident abuse

The following **Inspection Protocols** were used during this inspection:

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Safe and Secure Home

INSPECTION RESULTS

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NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

FLTCA, 2021, s. 6 (1) (c)

The licensee failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provide direct care to the resident. The residents' care plan indicated that the resident used specific transferring equipment for transfers and to follow the Safe Ambulation Lift Transfer (SALT) logo. Upon observation, the SALT logo indicated to use a different type of transferring equipment for transfers.

PSW's confirmed that the transfer equipment logo was not current, and the ADOC confirmed the assessment and logo should match the care plan. After the discrepancy was identified, the home updated with the residents' plan of care, assessment, and logo to provide clear direction to all staff.

Sources: resident's care plan; observation of resident's room; observation of staff interactions with the resident; interviews with PSW's; interview with ADOC #107.

Date Remedy Implemented: September 9, 2022.
(741126)

WRITTEN NOTIFICATION – PAIN MANAGEMENT

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 57 (1) 4

The licensee has failed to ensure when pain management interventions were provided to two residents, that the effectiveness of the pain management strategies were monitored.

In accordance with O. Reg 246 s. 11 (1) (b), the licensee is required to ensure that the pain management program, at a minimum, provides for residents' responses to, and the effectiveness of, the pain management strategies, and must be complied with.

Rationale and Summary
Specifically, staff did not comply with the home's Pain Assessment and Management policy and procedure.

1)The home's Pain Assessment and Management procedure directed staff to discontinue pain monitoring if pain was stable after 72 hours or there have been three consecutive days of pain rated three or less (based on individualized perception/observation of pain control). The procedure also directed staff to document the effectiveness of pain management interventions.

A) A resident sustained an injury after a fall and was monitored using the homes pain flow sheet for 72 hours of pain monitoring. The home discontinued the pain monitoring before the 72 hours timeframe had ended. The RPN and Interim DOC both acknowledged the pain monitoring for the resident should have continued for at least 72 hours.

B) A resident's pain flow sheet indicated the resident had sharp pain and the pain score was a 10/10. Routine analgesic was provided. The 30 minutes to one hour pain monitoring score was not documented. There was no documentation of re-assessment of the resident's pain score until eight hours later.

C) A resident had a pain flow sheet initiated and documented that the resident had sharp pain with a pain score of 2/10. A non-pharmacological intervention was documented as increase rest and decrease movement. The 30 minutes to one hour pain monitoring score was not documented, and there was no documentation of re-assessment of the resident's pain until two hours later.

Interim DOC #100 stated pain assessments were to be completed within 30 minutes to one hour after pain interventions were provided to residents and that the pain assessment scores should have been documented.

Not assessing residents' pain within 30 minutes to one-hour post intervention and discontinuing the resident's 72-hour pain monitoring before it was completed may have affected the ability of the staff to evaluate the effectiveness of the interventions and increased the risk of the resident's pain being unmanaged.

Sources: Interviews with a RPN and the Interim DOC #100, Pain Assessment and Management Policy, CARE8-P10, effective August 31, 2016, reviewed March 31, 2022, modified April 4, 2022, Pain Assessment and Management Procedure, CARE8-O10.02, effective August 31, 2016, reviewed March 31, 2022, Pain Flow Sheets and progress notes for 2 residents.

(741123)

2) The home's Policy titled Pain Assessment and Management, Index: CARE8-P10, Reviewed date: March 31, 2022, required the effectiveness of pain interventions to be monitored and resident outcomes to be evaluated and documented.

A resident was re-admitted to the home from the hospital after suffering from an injury. A pain flow sheet was initiated upon their return; however, was incomplete. Their pain was assessed, and analgesic was administered; however, their responses to the initiated pain interventions were not documented.

ADOC #103 confirmed that the pain flow sheet was incomplete.

By not documenting resident's responses to pain interventions, it posed an increased risk to the resident for inadequate or ineffective pain management.

Sources: Home's policy titled Pain Assessment and Management, Index: CARE8-P10, Reviewed date: March 31, 2022, Interview with ADOC #103, Pain flow sheet and progress notes.

(711428)

WRITTEN NOTIFICATION PAIN MANAGEMENT

NC#003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 57 (1) 2*

The licensee has failed to comply with strategies to manage the pain for a resident after they suffered an injury requiring hospitalization.

In accordance with O. Reg. 246/22 s. 11 (1) (b), the licensee is required to ensure the pain management program, at a minimum, provides for strategies to manage pain for residents and must be complied with.

Rationale and Summary
Specifically, the staff did not comply with the home's pain assessment and management policy and procedure.

The home's Policy titled Pain Assessment and Symptom Management Program, Index: CARE8-P10, Effective date: August 31, 2016, Reviewed date: March 31, 2022, Modified date: April 4, 2022, required:
- Resident's to be screened for pain using a standardized, evidence-informed clinical tool that is appropriate for the resident's cognitive level (PAINAD, Numeric Rating Scale, or Verbal Rating Scale, etc.).
- Upon completion of the Pain Screening Scale, all residents with identified pain must have 72-hour Pain Monitoring initiated and completed. All identified pain to be systematically treated with the appropriate strategies and interventions, which include non-pharmacologic – equipment, supplies, devices, and aids, etc.

Home's Policy titled Pain Assessment and Management, Index: CARE8-O10.02, Effective date: August 31, 2016, Reviewed date: March 31, 2022, procedure required staff to initiate pain monitoring upon identifying new or worsened pain and with a change in condition (i.e., post-fall, confirmed fracture).

A) A resident suffered an injury and was transferred to the hospital. At the time of the injury their pain score was 7/10. During the one-hour period when the pain was identified until the resident was transferred to the hospital, the resident did not receive any pain interventions.

B) A resident had a history of medical conditions, which prevented them from communicating their pain care needs. ADOC #103 stated that a PAINAD was required to assess pain care needs for residents with the identified medical conditions.

The resident returned from the hospital after a surgical intervention and pain assessments were not completed using a PAINAD and there was no 72-hour pain monitoring form initiated.

ADOC #103 stated that 72-hour pain monitoring needed to be initiated for residents returning from the hospital.

Failure to initiate pain management strategies post injury and hospitalization and assess their pain may have caused the resident unnecessary suffering, discomfort and increased their risk for delayed healing.

Sources: Home's Policy titled Pain Assessment and Symptom Management Program, Index: CARE8-P10, Reviewed date: March 31, 2022, Home's Policy LTC – Pain Assessment and Symptom Management Program, Index: CARE8-O10.02, Reviewed: March 31, 2022, Interview with ADOC #103, Pain screen, eMAR, New Admission Order Form, Progress Notes, Grand River Hospital – Emergency Documentation.

(711428)

WRITTEN NOTIFICATION SKIN AND WOUND CARE

NC#004 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 55 (2) (b) (i)*

The licensee has failed to ensure that when a resident had altered skin integrity from an injury that they had skin assessments and re-assessments using the home's skin and wound assessment app.

Rationale and Summary

In accordance with O. Reg, 246/22, s. 11 (1) (b) the licensee was required to ensure the skin and wound assessment program, at a minimum, provides a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

Specifically, the home failed to comply with the home's policy titled LTC-Skin Assessment, Index: CARE12-O10.08, Reviewed date: March 31, 2022, and Policy titled LTC-Skin and Wound re-evaluation, Index: CARE12-O10.07, Reviewed Date: March 31, 2022, that required nurses document skin and wound assessments, re-assessments/re-evaluations and wound progress using the skin and wound app.

On three different occasions when the resident developed wounds, staff did not use the homes clinically appropriate skin and wound app when completing the skin assessment

The residents' initial and secondary impaired skin integrity assessment, re-assessment and evaluations were not completed using a clinically appropriate skin and wound assessment app. Weekly evaluations of the initial area of impairment and secondary impairment were not completed. As a result, the two areas of skin impairment were not being monitored for possible infection and wound deterioration.

Sources: Home's Policy titled LTC-Skin Assessment, Index: CARE12-O10.08, Reviewed date: March 31, 2022, Interview with RN #124, Interview with ADOC #103, Interview with RPN #106, Skin and Wound Assessment, Progress notes, and Home's Policy titled LTC-Skin and Wound re-evaluation, Index: CARE12-O10.07, Reviewed Date: March 31, 2022.

(711428)

WRITTEN NOTIFICATION FALLS PREVENTION AND MANAGEMENT

NC#005 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 *s. 54 (1)*

The licensee has failed to ensure that a resident's vitals were monitored post fall.

In accordance with O. Reg. 246/22 s. 11 (1) (b) the licensee is required to ensure the fall prevention and management program, at a minimum, provides for strategies to reduce or mitigate falls, including the monitoring of resident's and must be complied with.

Rationale and Summary
Specifically, the staff did not comply with the home's Fall Prevention and Management Policy and procedure.

Home's Policy Fall Prevention and Injury Reduction Program, Description: Post-Fall Management, Index: CARE5-O10.05, Reviewed date: March 31, 2022, required a Post-Fall Assessment to be completed by the nurse immediately following the fall, including vital signs every shift for a minimum of 72 hours.

A Resident had a witnessed fall, and the post-fall assessment was completed; however, the vital signs were not assessed and instead, were marked as not applicable on the Post-Fall Assessment form.

When their vital signs were not monitored as required post fall, it may have increased their risk for another fall and delayed necessary treatment.

Sources: Home's Policy Fall Prevention and Injury Reduction Program, Description: Post-Fall Management, Index: CARE5-O10.05, Reviewed date: March 31, 2022, Interview with ADOC #103, Interview with RPN, progress notes, and vitals assessment.

(711428)

WRITTEN NOTIFICATION REPORTS AND CRITICAL INCIDENTS

NC#006 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 115 (1) 1.

The licence failed to ensure that the Director was immediately informed, in as much detail as possible when a fire occurred in the home's laundry room.

Rationale and Summary
A fire occurred in the home's laundry room that resulted in the home implementing their fire emergency response plan, and dispatch of fire and emergency services.

The home did not call the Long-Term Care Action Line immediately to report the emergency or submit a critical incident (CI) report to the Director until the following day.

Failure to report the emergency immediately to the Director put the residents, staff, and emergency personal at risk of not having additional resources from the MTLC should the emergency have escalated.

Sources: CI report, Interview with the Executive Director

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WRITTEN NOTIFICATION MAINTENANCE SERVICES

NC#007 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s.96(2)(a)

The licensee failed to ensure that procedures were developed and implemented to ensure that the home's dryers were kept in good repair, maintained, and cleaned at a level that at minimum met the manufacturer specifications.

Rationale and Summary
A fire was observed in one of the five dryers that were in operation in the homes' laundry room.

The home had a preventative maintenance schedule and procedures that outlined daily and monthly maintenance on the dryers.

There were two consecutive months in 2022, the home did not have documentation that stated the monthly preventative maintenance was completed. Furthermore, the home did not implement the necessary monthly procedures as per the manufacture nor did they implement any quarterly, bi-annual, or annual maintenance and cleaning on the dryers as specified in the manufacture instructions titled “Tumble Dryers”, Installation/Operation/Maintenance original instructions April 2019.

Failure to implement a maintenance schedule and plan for the home’s tumble dryers as per the recommendations of the manufacturer put residents at risk when there was potential of a dryer malfunction and delay in laundry services provided to residents.

Sources: Interview with Maintenance Manager, Manager of Coinamatic, Manager of Power Vac Ontario, Staff members, record review of document from environmental services manual, Issue Date: January 21, 2015, Revision Date: December 1, 2017 E: Maintenance Department Section: Laundry Equipment, Subject: Dryers, Index I.D. ES E-55-10. Reviewed document titled “Tumble Dryers”, 50 Pound (25 Kilogram) Capacity, 75 Pound (34 Kilogram) Capacity, 15 Digit Model Numbers with 2 in 12th Position, Installation/Operation/Maintenance Original Instructions, Part No: 70457901ENR18, April 2019. Invoice from Power Vac Services #127324, Infraction Report #26454, 26451, 26453, 26452 from Kitchener utilities, Preventative Maintenance Task #20126956 and #2046966

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WRITTEN NOTIFICATION MAINTENANCE SERVICES

NC#008 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 96(2)(e)

The licensee has failed to ensure that procedures were developed and implemented to ensure that the home’s dryers were inspected by a qualified individual at least annually, and that documentation of the inspection was kept.

Rationale and Summary

The home utilized a company on an annual basis to complete dryer maintenance on all the home’s five gas dryers.

The home’s manufacture instructions for the dryers stated that, on an annual basis to remove the burner tubes and clean them with water and a brush.

The Commercial Operations Manager at PowerVac Ontario stated that the company performed annual cleaning of the vents that included the duct work that connected to the back of the dryer to where the ducts vented outside. They cleaned the compartment where the lint tray was located and the areas around the dryers. They did not complete any maintenance or cleaning on the motors or burners as their staff were not qualified gas technicians.

Failure to ensure that a qualified individual provided service to the home for the tumble dryers as per the recommendations of the manufacturer at least annually put residents at risk when there was a potential of dryer malfunction and delay in laundry services provided to residents.

Sources: Maintenance Manager, Manager of Power Vac Ontario, Staff members, record review of document titled "PowerVac Ontario invoice #127324, review of document "Tumble Dryers", 50 Pound (25 Kilogram) Capacity, 75 Pound (34 Kilogram) Capacity, 15 Digit Model Numbers with 2 in 12th Position, Installation/Operation/Maintenance, Original Instructions, Part No: 70457901ENR18, April 2019.

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WRITTEN NOTIFICATION ACCOMODATION SERVICES AND PROGRAMS

NC#009 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 92(2)

The licensee has failed to ensure that services provided under the maintenance program for the home's dryers, that required the service to be completed by a service provider that was not an employee of the licensee, there was a written agreement with the service provider that set out the service expectations.

Rationale and Summary

The home utilized tumble dryers in the laundry room to dry resident and facility linen as part of the homes' laundry service program.

The manufacture instructions for the dryers that were provided during the inspection specified that maintenance on the dryers was to be completed daily, monthly, quarterly, semi-annual, and annual.

The tasks outlined in the manufacture instructions had specific timelines for each task to be completed and stated that the cleaning, inspection, and maintenance of the dryers, were to include the motor, burner tubes, internal/external ducts, check for gas leaks, and check electrical. A maintenance staff member stated that they did not perform the specific tasks.

The Executive Director (ED) stated that the home did not have a service agreement for the maintenance on the dryers as the maintenance staff in the home completed the maintenance daily and monthly. The home utilized Coinamatic for servicing of the dryers, they did not have

a service agreement and they only contacted the company when there was an issue. The ED stated that they did not have a service agreement with PowerVac Ontario to complete their annual dryer vent cleaning.

Failure to ensure that the home had a service agreement for the maintenance of the dryers that set out the service expectations as set out in the manufacturer instructions may impact residents' daily routine with the home's laundry services and equipment when there was not a service agreement with a qualified service provider.

Sources: Interview with Executive Director, Maintenance Manager, Manager of Coinamatic, Manager of Power Vac Ontario, Staff members, record review of document from environmental services manual, Issue Date: January 21, 2015, Revision Date: December 1, 2017, E: Maintenance Department Section: Laundry Equipment, Subject: Dryers, Index I.D. ES E-55-10. Reviewed document titled "Tumble Dryers", 50 Pound (25 Kilogram) Capacity, 75 Pound (34 Kilogram) Capacity, 15 Digit Model Numbers with 2 in 12th Position, Installation/Operation/Maintenance Original Instructions, Part No: 70457901ENR18, April 2019.

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