Ontario

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

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Modified Public Report (M)

Report Issue Date: March 17, 2023

Inspection Number: 2023-1205-0003

Inspection Type:
Proactive Compliance Inspection

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Forest Heights, Kitchener

Lead Inspector	**Inspector Digital Signature**
Nuzhat Uddin (532)	Nuzhat J Uddin Digitally signed by Nuzhat J Uddin Date: 2023.03.21 12:22:53 -04'00'

Additional Inspector(s)
Helene Desabrais (615)

MODIFIED PUBLIC INSPECTION REPORT SUMMARY

The licensee report has been revised to reflect the legislation specified for non-compliance (NC) #002 Written Notification. O.Reg. 246/22, s. 123 (3)(a).

The Proactive Compliance Inspection #2023-1205-0003 was completed on February 7, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

January 24-27 and 30, 2023
February 2-3, 6-7, 2023

The following intake(s) were inspected:

- Intake: #00018750-Proactive Compliance Inspection

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

Infection Prevention and Control
Medication Management
Food, Nutrition and Hydration
Residents' and Family Councils
Quality Improvement
Falls Prevention and Management
Skin and Wound Prevention and Management
Pain Management
Prevention of Abuse and Neglect
Resident Care and Support Services
Residents' Rights and Choices
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control (IPAC)

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (2) b.

The licensee has failed to ensure that there was in place a hand hygiene (HH) program that was in accordance with the Infection Prevention and Control (IPAC) Standard issued by the Director pursuant to section 102 (2) (b) of the Regulation under the Fixing Long-Term Care Act (FLTCA), 2021.

Rationale and Summary:

According to O. Reg 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC. The IPAC Standard for Long-Term Care Homes (LTCH) dated April 2022, provided additional requirements for IPAC programs in LTCHs.
The IPAC Standard section 10.4 h) states that the HH program should include support to residents to perform HH prior to receiving meals and snacks.

A) On January 24, 27, and 30, 2023, it was noted that staff did not assist residents with hand hygiene before and after meals. The home's "Resident Hand Hygiene" policy effective October 31, 2022, required that staff assist residents to clean their hands before and after meals.

ABHR was available at point-of-care and in the dining rooms; however, staff did not assist the residents with hand hygiene (HH).

The residents who could independently complete HH were not encouraged and the residents that were not able to independently perform hand hygiene were not assisted. This presented increased risk to residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

The IPAC Lead said staff were expected to assist residents with performing HH before they ate their meals. It was expected that staff remind and offer HH assistance to independent residents and provide physical assistance to residents with cognitive or physical impairments.

B) A registered staff checked a resident's blood glucose and then picked a up dirty cup but did not perform HH. At 1400 hours the same registered staff administered medications to a resident and did not perform HH before or after the medication administration. At 1436 hours they continued with the administration of medication to a different resident without performing HH.

The registered staff stated that they were aware of the HH policy but if they continuously washed their hands then they would be dry.

Not ensuring that infection prevention and control measures were implemented as required increased the risk of infectious disease transmission throughout the home.

Sources: Resident Hand Hygiene" policy, observations on home areas, interview with residents and staff.

[532]

WRITTEN NOTIFICATION: Medication Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 123 (3)(a)

The licensee shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. The written policies and protocols must be, (a) developed, implemented, evaluated, and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:

The home's policy titled "LTC - Medication Management" review date: March 31, 2022, and modified date: July 19, 2022, stated the following:
"Medication will not be prepared in advance under any circumstances.
Two Resident identifiers are required before administering medications.
Oral Medication must be observed for ingestion, otherwise, it cannot be considered administered".

A registered staff was observed administering medications to multiple residents at the same time without ensuring that they had the right resident.

The registered staff acknowledged giving medications to more than one resident at a time.

The DOC stated that nurses were not supposed to administer medications to multiple residents at the same time because of the risk to the resident as the nurse can administer the wrong medication to the wrong resident. They stated that there should be a check completed to ensure that each resident received the right medications and further stated medication should not be pre poured as per policy.

Not ensuring that appropriate checks were completed prior to administering medication, preparing medication in advance and by administering medications to multiple residents at the same time placed the residents at potential risk of harm.

Sources: Clinical records i.e., Medication administration record (eMAR), Medication Management policy, Medication administration observations and interviews with the DOC and registered staff.
[532]

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 140 (6)

The licensee has failed to ensure that no resident administers a drug to themself unless the administration has been approved by the prescriber in consultation with the resident.

Rationale and Summary:

A registered staff left oral medications on the table for two residents and an insulin pen to a resident for self-administration.

A registered staff did observe the administration of medications for two residents and shared that they regularly leave the medications on the table for these residents as they were cognitive; however, the insulin pen was calibrated by staff and was self-administered by the resident.

The residents had no physician's order for self-administration.

Allowing residents to administer medications to themselves without being approved by the prescriber and not supervising the residents during a medication administration pass placed residents at moderate risk of harm.

Sources: Clinical records i.e., Medication administration record (eMAR), physician's order, plan of care, Administration of medication policy, Medication administration observations and interviews with the DNC and other staff.

[532]

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 148 (2) 1.

The drug destruction and disposal policy must provide for the following:
That any controlled substance that was to be destroyed and disposed of was to be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction and disposal occurs.

The home's policy titled- Narcotics and Controlled Drugs Management – ON" effective date: August 31, 2016, Review date: March 31, 2022. stated the following under "Disposal of Narcotic and Controlled Drugs, and Discontinued Drugs: Narcotics and controlled drugs for drug destruction will remain locked in the narcotic bin on the medication cart and will be counted and signed by two Nurses at the beginning and end of each shift as per usual protocol until they are removed for drug destruction.

Rationale and Summary:

On January 24, 2023, it was noted that narcotics and controlled drugs for destruction were kept and locked with controlled substances that were available for administration. These drugs were discontinued

but were not separated from controlled substances that were available for administration.

Not separating drugs for destruction from drugs that are available for administration could place residents at risk of harm.

Sources: Policy called "LTC - Narcotics and Controlled Drugs Management – ON, drug destruction and disposal observations and interview with the nursing staff and the DOC.
[532]

COMPLIANCE ORDER CO #001 Nutritional care and dietary services

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 74 (2)(a)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The Licensee has failed to comply with O. Reg 246/22 s. 74 (2)(a)

The licensee shall:

a) Comply with their "Pleasurable Meal Service Strategies Policy", specifically with respect to having adequate staff in the dining room during all meal times as per posted mealtimes.

b) Provide all staff including the registered staff on the Clark home area training on the "Pleasurable Meal Service Strategies policy".

c) Document the education, as outlined in b), including the date, format, staff attending the training, including the staff member who provided the education.

d) Conduct an audit of all three meals per day for 7 days and document the following:

1. How many staff were present to assist with meals;
2. Whether the meal service table rotation was followed as per policy;
3. Whether the meals were commenced on time as per posted meal times;
4. Whether the tables were set ahead of resident arrival;
5. Whether beverages were provided to residents upon their arrival;
6. Whether any residents were upset or discouraged with the meal service;
7. The duration of each meal service.

e) At a minimum the audit shall include the date, which meal was audited, the name of the staff member who conducted the audit and a post-audit assessment for required interventions, if any, and an action plan to implement the interventions. The audit results shall be made available for review upon request by an inspector.

Grounds

The licensee has failed to ensure that the nutritional care and dietary services program was implemented.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is an organized program of nutritional care and dietary services including the implementation of policy of the home, specifically that meal service is complied with.

Specifically, the home's "Pleasurable Meal Service Strategies" policy (last reviewed June 30, 2022) specified that staff, participating in meal services were to be available and in the dining room by the posted meal times and the dining room was to be a calm and pleasant environment. The meal service table rotation schedule was to be followed and commenced on time as per posted meal times.

Rationale and Summary:

On a identified dining area, nursing staff were not available to serve the residents as per posted mealtimes. Nursing staff were observed sitting at the nursing station at 1210 hours. The dining room was not a calm and pleasant environment as residents appeared to be anxious and were requesting the dietary staff to serve them soup, cutlery, juice, and coffee. They were loudly expressing their concerns to the dietary staff nearby, disturbing the surroundings for others.

The identified resident plan of care indicated that they were at high nutritional risk.

On January 30, 2023, at approximately 1223 hours, no main course had been served to any of the residents on the right side of the dining room. Residents expressed disappointment and concern over waiting for an extended period. Beverages were not set at each table after the residents had arrived as per usual routine.

A number of resident complained that the meal service was always late for all three meals and did not understand why the front of the dining room was always served first. They stated that the front of the dining room was served by the dietary staff and it was always more organized but did not understand why the back side had to wait for so long.

A resident waited until 1225 hours and left the dining room without being served their meal. They stated that they were not going to wait for 45 minutes to be served.

A staff member stated that some staff take their break during residents' scheduled meal times.

The DOC said that a complaint was received from a family member who stated that no lunch was received by resident on a specified date. The DOC stated that pleasurable dining was part of their home's action plan as it was identified as a concern through their own audits, however, it was work in progress and still required some improvements. It was the home's expectation that staff start and be available to serve the residents in the dining room as per posted meal times, cutlery and beverages distributed after residents were in the dining room and the dining room was a calm and pleasant experience for the resident.

The residents were distressed when staff were not available to participate in the dining service by the posted meal times and in some cases the residents left the dining room without eating which aside from making the dining service an uncomfortable experience, was a risk to the residents.

Sources: "Pleasurable Meal Service Strategies" policy reviewed June 30, 2022, plan of care for residents, interview with residents, DOC and other staff.

[532]

This order must be complied with by March 31, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.