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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 21, 2018	2018_491647_0004	001798-18	Resident Quality Inspection

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

Oak Terrace
291 Mississaga Street West ORILLIA ON L3V 3B9

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

JENNIFER BROWN (647), DEBBIE WARPULA (577), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 5-9 and 12-16, 2018.

The follow critical incidents (CIS) were completed during with this inspection:
Log #010223-17 and Log #022998-17 were related to prevention of abuse and neglect;
Log #010898-17 was related to prevention of abuse and neglect, reporting certain matters to the director, and behaviors and altercations;
Log #012108-17 was related to fall prevention and management;
Log #025159-17 was related to plan of care;
Log #028383-17 was related to infection prevention and control.

The following complaints were completed during this inspection:
Log #007447-17 was related to falls prevention and management and resident to resident altercations;
Log #009808-17 was related to nutrition care and hydration programs, falls prevention and management, continence care and bowel management, and nursing and personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Dietitian (RD), Nutrition Manager (NM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Cook, Dietary Aides, Housekeepers, Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in resident home areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 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	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 following rights of residents were fully respected and promoted: the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

A Critical Incident Report (CIS) report was received by the Director on an identified date in September 2017, which alleged emotional abuse towards resident #011 and a breach of confidentiality concerning resident #025. Further details of the report confirmed that the personal health information of resident #025 was shared by a direct care staff member with another staff member in an area while other residents were present.

Inspector #577 reviewed the home’s policy titled "Privacy - Legal2-P10" last revised November 2017, which indicated that Revera recognized each individual’s right to keep personally identifiable information about them private. They were committed to protecting such information by ensuring that it was treated with care and was not used or disclosed in ways that had not been consented to. Employees were responsible for ensuring that they were informed of and knowledgeable about their responsibilities to protect privacy, which included the collection, use disclosure, retention and disposal of personally identifiable information.

During an interview with resident #011, they reported to Inspector #577 that direct care staff member #121 was discussing resident #025’s medical condition with a co-worker.

Inspector #577 spoke with direct care staff member #121 who reported that they were in with another co-worker, and had discussed the medical condition of resident #025 and identified them by name, while other residents were present in the room.

During a review of the home’s investigation file and interview with the Administrator, it was confirmed that direct care staff member #121 had breached confidentiality by disclosing the personal health information of resident #025. [s. 3. (1) 11. iv.]

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 following rights of residents were fully respected and promoted: the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health and and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Inspector #196 reviewed medication incident reports involving residents including:
- A report dated on an identified date in February, 2017, that identified resident #005 was administered another resident's medications, in error. The report did not identify the

notification of the medication incident to the resident, and did not record the immediate actions taken to assess and maintain the resident's health;
- A report dated on an identified date in November, 2017, that identified resident #023 was administered an additional dose of an identified medication, in error. The report did not identify the notification of the medication incident to the resident or substitute decision maker (SDM) and did not record the immediate actions taken to assess and maintain the resident's health.

The progress notes for resident #005 were reviewed by the Inspector and did not identify the notification of the medication incident to the resident and did not include the immediate actions taken to assess and maintain the resident's health.

The progress notes for resident #023 were reviewed by the Inspector and did not identify the notification of the medication incident to the resident or SDM and did not include the immediate actions taken to assess and maintain the resident's health.

The home's Medication Incident policy, titled "LTC - Medication Risk Management-CARE13-030.01", dated November 2017, was reviewed. The policy read, "For all Resident-related medication incidents, there will be a brief factual description description of the incident, treatment, and intervention documented in the interdisciplinary progress notes. The Resident's condition will be monitored and documented for 24 hours or as per Physician Order" and, "The Physician/Nurse Practitioner (NP) /Substitute Decision Maker (SDM)/family will be informed of all Resident-related incidents. The Nurse will determine whether the Physician/NP/SDM/family requires notification immediately, within the next 12 hours or at the next visit."

During an interview with the Director of Care (DOC), they confirmed to the Inspector that the medication incident reports for both resident #005 and resident #023 did not include the notification of the resident themselves or the SDM, that the progress notes did not include documentation and did not identify the actions taken to assess and maintain the resident's health in relation to the incidents. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction was, documented, together with a record of the immediate actions taken to assess and maintain the resident's health and and reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, and to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clauses (a) and (b), 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 shall ensure that staff participate in the implementation of the infection prevention and control program.

During an identified meal service on February 14, 2018, at an identified time, Inspector #196 observed cook #113 rub their neck and hair line with their hand and then proceeded to retrieve food items with their hand and plate them for service to residents.

A review of the home's policy titled "Safe Food Handling Practices, CUL5-010.01", dated December 4, 2016, identified:
- "Touching foods directly with bare hands should be avoided whenever possible."
- "During food service it is important to follow safe serving practices: avoid touching food with bare hands."

During an interview with Nutrition Manager (NM) #107, they reported to the Inspector that the cooks can wear gloves or use tongs to serve hand held food items and were not to use bare hands to touch and serve food. NM #107 also reported that the use of bare hands to touch and serve the wraps during the above mentioned meal service observation, had breached the infection prevention and control (IPAC) expectations of the home. [s. 229. (4)]

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, to be implemented voluntarily.

WN #4: 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. (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 care set out in the plan of care was provided to the resident as specified in the plan.

During an identified meal service on February 14, 2018, at an identified time, Inspector #196 observed resident #003 drink fluids from a cup and eat an identified meal with a spoon. The resident's hand had a tremble as they scooped their food with a spoon close to the edge of the plate.

The resident's care plan indicated the focus of "Requires extensive assistance for eating or swallowing" and the interventions included the use of an assistive device for food and fluids.

During an interview with direct care staff member #119, they reported to the Inspector that they were unfamiliar with resident #003. They went on to confirm that this resident did not have an identified assistive device.

During an interview with dietary staff member #120, they reported to the Inspector that the direct care staff members usually provide an assistive device for fluids to resident #003 and the cook provided the assistive device for food.

During an interview with dietary staff member #113, they confirmed to the Inspector that the resident was to be provided with an assistive device and that they had missed giving this during the identified meal service.

NM #107 reported to the Inspector that the staff member that provided the beverage, were to provide the assistive devices, and the cook was to provide the other assistive device. The NM went on to confirm that resident #003's plan of care was not followed during the identified meal service on February 14, 2018. [s. 6. (7)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

A CIS report was received by the Director on an identified date in September, 2017, related to staff to resident abuse. In the report, resident #011 had reported to an employee of the home that direct care staff member #121 had abused them, causing anxiety and stress.

Under O. Reg. 79/10, verbal abuse is defined as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's well-being, dignity or self-worth, that is made by anyone other than a resident".

A review of the home's policy titled "Resident Non-Abuse Program - ADMIN1-P10-ENT" last revised July 31, 2016, defined verbal and emotional abuse as inappropriate verbal or non-verbal communication directed towards the resident; any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, that were performed by anyone other than a resident. Examples given were inappropriate tone of voice, yelling or scolding. Any form of abuse or neglect by any person interacting with residents, whether through deliberate acts or negligence, would not be tolerated.

A review of the investigation notes by Inspector #577 revealed a disciplinary letter from the home to the identified direct care staff member #121 dated on an identified date in October, 2017. The letter revealed that the results of the investigation were, that statements contained in the allegation of abuse and breach of confidentiality were supported by witnesses that were present at the time of both incidents.

During an interview with resident #011, they reported to Inspector #577 that the direct care staff member #121 approached them in their room, and resident reported that they were upset that direct care staff member #121 had spoken to them in an abusive manner.

During an interview with the Administrator, they reported to the Inspector that as a result of the investigation, direct care staff member #121 received discipline concerning their conduct toward resident #011, and that verbal abuse had occurred. [s. 20. (1)]

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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

Issued on this 22nd day of March, 2018

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

Original report signed by the inspector.