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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 25, 2014	2014_323130_0016	H-001043-14	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

RIDGEVIEW
385 HIGHLAND ROAD WEST, STONEY CREEK, ON, L8J-3X9

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

GILLIAN TRACEY (130), BARBARA NAYKALYK-HUNT (146), ROSEANNE WESTERN (508), THERESA MCMILLAN (526)

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): August 6, 7, 8, 11, 12, 13, 14, 2014

Please note: the following critical incidents: H-000203-14, H-000437-14, H-000882 -14 and follow-up: H-000690-13, were inspected simultaneously with this RQI.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Corporate Resident Assessment Instrument (RAI) Coordinators, Corporate Clinical Consultant, Support Services Manager, Environmental Services Manager, Continuous Quality Improvement Manager (CQIM), Registered Staff, personal support workers, dietary staff, residents, President of Residents' Council, President of Family Council and families.

During the course of the inspection, the inspector(s) Toured home areas, interviewed staff, reviewed clinical records, relevant policies and procedures, minutes of meetings, investigative notes, observed meal service and care, interviewed staff, residents and families.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided as specified in the plan.

A) The plan of care for resident #045 was reviewed and indicated the resident was at moderate nutritional risk. The plan directed staff to provide prescribed snack: fortified pudding at evening snack. On August 12, 2014, at 1530 hours, the fortified pudding labeled for the resident was noted to be in the servery fridge. The resident was interviewed and confirmed they were not offered the fortified pudding at the 1400 hour snack pass. (Inspector #130)

B) The plan of care for resident #046 was reviewed and indicated the resident was at high nutritional risk. The plan directed staff to offer prescribed snack: fortified pudding afternoon and evening snack. On August 12, 2014, at 1530 hours, the fortified pudding labeled for the resident was noted to be in the servery fridge. The resident was interviewed and confirmed they were not offered the fortified pudding at the 1400 hour snack pass. (Inspector #130)

The personal support worker assigned to distribute the snacks on August 12, 2014 at 1400 hours, confirmed they did not offer the snacks to these residents.(Inspector #130) [s. 6. (7)]

2. The licensee failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed.

A) Resident #028 had a diagnosis that contributed to the resident having involuntary movements of their extremities. The resident had sustained multiple falls over a three month period in 2014. All of which involved the resident's movements causing them to slide out of bed onto the adjacent falls mat. On two observed dates in 2014 resident #028 was observed to be lying in bed with a bolster placed beneath the sheets beside the resident on the open side of the resident's bed. Non registered staff described applying the bolster using a pillow or some blankets beneath the sheets. The latest update to the plan of care did not include the bolster as an intervention for the resident and did not direct the staff in its use. The Continuous Quality Improvement Manager (CQIM) stated that the physiotherapist had recommended that staff apply a bolster while the resident was in bed and confirmed that the assessment had not been documented or the plan of care revised. Registered staff confirmed that the plan of care regarding the use of a bolster when resident was in bed was not documented. (Inspector #526) [s. 6. (10) (b)]

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 care set out in the plan of care is provided as specified in the plan and that the plan is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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 a person who had 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.

A) Resident #005 was observed to have unexplained bruising on an identified date in 2014; a PSW reported it to the charge nurse. The home later submitted a critical incident to report the bruising of unknown origin as suspected improper care,

however, the report was not submitted immediately.(Inspector #146)

B) Resident #042 was observed to have bruising and pain on an identified date in 2014, by a PSW who reported it to the charge nurse. The injury was x-rayed and confirmed an injury later the same day. The home submitted a critical incident identified as a mandatory report related to improper/incompetent care on a specific date in 2014. The DOC confirmed the above information and confirmed the late reporting. (Inspector #146)

C) On an identified date in 2014, resident #043 reported to a PSW that during the evening on a specific date in 2014, a staff member came into their room, grabbed them under their arms and threw them onto their bed as the resident was close to slipping onto the floor from the side of their bed. The resident stated that the action was very rough and they hit their body on the bed rail. According to the resident, as the staff person was leaving the resident's room they stated "now don't you move out of this bed, I don’t want to hear another chirp out of you", or something similar to that. They informed registered staff and the resident repeated the details of the incident to the registered staff person. Neither the PSW nor the registered staff immediately reported the incident to the Director. On a specific date in 2014 the family reported to registered staff that the resident was afraid that the same nurse would care for them again that evening. Progress notes indicated that the resident's family reported to registered staff that the resident was "afraid to call nursing staff for help, because the nurse was rough". In 2014, during an interview with the Inspector the resident confirmed that the incident occurred as described above and stated that they felt intimidated by the actions of the staff person. The Director of Care (DOC) confirmed that the home’s administration became aware of the incident on a specific date in 2014, at which time the Resident Services Coordinator interviewed the resident. The next day the DOC submitted a Mandatory Report to the Director for alleged abuse-intimidation. The DOC confirmed that, at the time of the incident, the home’s policy did not direct staff to immediately notify the Director of certain matters involving alleged abuse of a resident. The DOC confirmed that suspected abuse of a resident by anyone that resulted in harm or a risk of harm to a resident was not immediately reported to the Director. (Inspector #526) [s. 24. (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 a person who has reasonable grounds to suspect that abuse to a resident by a staff member has occurred, immediately reports the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. O. Reg. 79/10, s. 71 (3).

A) On August 11, 2014, residents #015 and #044 were not offered a between-meal beverage in the afternoon. Both residents were observed to be awake in their beds at 1440 hours. According to the written plans of care, both residents were identified to be at high nutritional risk. Staff interviewed confirmed the two residents were not offered a snack during the afternoon snack pass. (Inspector #130) [s. 71. (3) (b)]

2. The licensee failed to ensure that each resident was offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

A) On August 11, 2014, residents #015 and #044 were not offered a snack in the afternoon. Both residents were observed to be awake in their beds at 1440 hours. According to the written plans of care, both residents were identified to be at high nutritional risk. Staff interviewed confirmed the two residents were not offered a snack. (Inspector #130) [s. 71. (3) (c)]

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 each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #4: 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 :

1. The licensee has failed to ensure that they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

A) The President of the Family Council was interviewed on August 14, 2014, and confirmed during this interview that the satisfaction survey was developed at the corporate level and that the Council was not involved in the development of the survey. (Inspector #130) [s. 85. (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 they seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home.

A) On August 13, 2014, all four home areas were inspected and found to store residents' topical creams in an area accessible to personal support workers who had not been trained or delegated to administer topical medications. Registered staff confirmed that non registered staff had access to topical medications. Six non registered staff interviewed stated that they had not received training or delegation by registered staff to administer topical medications. The DOC confirmed that non registered staff who had not been delegated or trained to administer topical medications should have been restricted from areas where these medications were stored. (Inspector #526) [s. 130. 2.]

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 all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. The home's Documentation/Health Records policy LTC-D-20 last revised August 2012 indicated that "Documentation should be able to demonstrate: an assessment of resident's health care status, the care that has been planned and provided, and whether the problem was resolved; significant events during a care episode; the interventions used to respond to a resident's goals/needs; the resident's response to interventions taken and any subsequent action taken".

A) The home's critical incident investigation notes indicated that on a specific date in 2014, registered staff entered resident #043's bed room and found them sitting at the end of the bed, hanging off the side. The RN assisted the resident as they appeared they were going to fall head first onto the floor. The RN picked the resident up from under their arms and supported them while trying to release the bed rail so the resident could be put back onto the bed. Both bed rails were up and the resident was holding tightly onto the right bed rail with both hands and did not let go when directed. The RN struggled with supporting the resident and finding the release for the bed rail, but eventually managed and the resident was brought up onto the bed. The investigation notes also indicated that the registered staff stated that they did not document the incident in the resident's health record. The progress notes on the identified date in 2014 stated "during the night resident slept and was cooperative". The DOC confirmed that the registered staff should have documented this incident in the resident's health record and failed to do so.(Inspector #526) [s. 30. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee did not ensure that a resident received individualized personal care, including hygiene and grooming on a daily basis.

A) Resident #028 was noted to have facial hair on their upper lip and in nostrils and debris in their teeth on four observed dates in 2014. The resident was noted to have dried food around their mouth on one of the observed dates. The resident's spouse stated that they thought that the resident's grooming could be better. Non registered staff interviewed confirmed that they did not remove the resident's facial hair. (Inspector #526) [s. 32.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

A) The Annual Minimum Data Set (MDS) Assessment completed on an identified date in 2014, for resident #021, indicated the resident was usually continent of bowel and frequently incontinent of bladder. The Quarterly MDS Assessment completed on a later date in 2014, indicated there had been no change in the resident's continence status. The Quarterly MDS Assessment completed on a later date in 2014, indicated the resident was now frequently incontinent of both bowel and bladder. The RAI Coordinator confirmed there was no assessment conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the resident's continence status had worsened. (Inspector #130) [s. 51. (2) (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 26. (3)	CO #001	2013_201167_0025	130

Issued on this 23rd day of October, 2014

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