Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
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	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public
Date(s) of inspection/Date de l'inspection March 17 & 18, 2011	**Inspection No/ d'inspection** 2011_192_2849_16Mar205803	**Type of Inspection/Genre d'inspection** Critical Incident H - 00528

Licensee/Titulaire
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 Long Term Care Centre, 385 Highland Road West, Stoney Creek ON L8J 3X9

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville Nursing Inspector #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents.

During the course of the inspection, the inspector: Reviewed medical records, policy and procedure, observed resident/staff interaction.

The following Inspection Protocols were used during this inspection: Critical Incident Response, Falls Prevention, Pain, and Responsive Behaviours Inspection Protocols.

Findings of Non-Compliance were found during this inspection. The following action was taken:

9 WN
5 VPC
2 CO: CO # 001, #002.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(1)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. A specified resident was admitted, on the day of admission there was an episode of verbal aggression directed toward staff. On a specified date there was an interaction with a co-resident resulting in injury. The plan of care for the specified resident does not address how to manage physical or verbal aggression directed toward co-residents or staff.
2. Interventions provided in the plan of care for a specified resident are vague and generic and do not address changes in the residents behaviour over the course of the day, or known triggers.
3. The plan of care for a specified resident does not include the use of monitoring devices, the use of bed rails, or information related to care directions.
   A staff member interviewed was able to identify use of one monitoring device, but was not aware of a second device and indicated that the resident should have assistance to move from side to side; contrary to Guidelines from the physiotherapist.
4. The plan of care for a specified resident indicates under Mobility that the resident requires 1 staff and a wheelchair for locomotion on and off the unit. The resident was observed walking with a walker and the assistance of one staff.
5. The use of bedrails is not identified in the plan of care for a specified resident. Documentation on the flow sheet indicates that two rails are consistently in place. On observation the left rail is in the up position. During interview the resident indicates a preference for only one rail.
6. A specified resident has had several episodes of responsive behaviours, frequently directed toward co-residents. Interventions in the plan of care are vague and do not provide clear interventions. Documentation on the progress notes indicates that redirection is frequently ineffective. On interview the Personal Support Worker was unable to verbalize what actions should be taken to minimize harm to the resident or other residents when responsive behaviours occur.
7. A specified resident has developed a wound. The plan of care does not indicate interventions for the relief of pain. There is no clear direction for staff on how to relieve pressure to the area.

Inspector ID #:	Nursing Inspector #192

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 by ensuring that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(2)

The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Findings:

1. A specified resident had a surgical intervention and has acquired a wound. Documentation on the progress notes indicates that the resident's pain is not well controlled. On interview the resident indicated that there was pain. The resident's activities of daily living are impacted by the pain. No pain assessment was completed as evidenced by a review of the medical record, point click care and in discussion with the Registered Practical Nurse.

2. A specified resident was noted to have one bed rail in the up position, it was indicated during interview that this is the resident's preference. The flow sheet for the resident indicates that two bed rails are consistently in place. There is no indication in the medical record that an assessment has been completed to determine the resident's safety and use of bed rails. There is no bed rail use indicated in the plan of care.

3. A specified resident had a fall risk assessment tool completed, sustained a fall with injury and a fall that resulted in transfer to hospital. No fall risk assessments had been completed following the documented falls or with ongoing documentation related to activities that put the resident at risk for further falls.

Inspector ID #:	Nursing Inspector # 192

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #3: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(4)(a)

The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

Findings:

A specified resident sustained an injury that resulted in hospitalization, returned to the home with analgesic for pain. The analgesic was changed. During interview with the resident it was identified that there was ongoing pain. No pain assessment has been completed for the specified resident.

1. Flow sheets for the specified resident contain information from the personal support workers indicating that there is pain daily on every shift.

2. Analgesics were changed. Documentation indicates that the analgesic given had little effect. No alternative intervention was documented.
3. Physiotherapy progress note indicates that the resident was re-assessed and was complaining of having a lot of pain.
4. The plan of care for pain does not address the location of all pain and plan of care for skin integrity does not address pain in the area.

There is a lack of interdisciplinary assessment related to pain management for this resident even though pain is identified by members of the team as occurring as frequently as each shift daily.

Inspector ID #:	Nursing Inspector #192

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 ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with *Long-Term Care Homes Ac, 2007, S.O. 2007, c.8,* s. 24(1)2.

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:

(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.

Findings:

A critical incident occurred. As a result of the interaction, the specified resident sustained a wound that was treated in the home; a specified resident was transported to hospital with injury.
Immediate reporting is required when there is actual or suspected abuse of a resident by anyone, resulting in harm.

Inspector ID #:	Nursing Inspector #192

WN #5: The Licensee has failed to comply with O. Reg. 79/10 s. 134(a)

Every licensee of a long-term care home shall ensure that, when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

Findings:

A specified resident was ordered analgesic on return from hospital. Medication was given as ordered. No evaluation of this medication was documented.
A specific medication was also ordered for breakthrough pain. No time of administration is indicated on the Medication Administration Record. The effect of the dose is not recorded.
A specific analgesic was given. The effect of the medication is not consistently recorded on the PRN (as

necessary) Medication record or in the progress notes.

Inspector ID #:	Nursing Inspector #192

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 when a resident is taking any drug there is monitoring and documentation of the resident's response and the effectiveness of the drug, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O. Reg. 79/10 s. 26(3)5

A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Findings:

The progress notes indicate that a specified resident was involved in numerous episodes of responsive behaviours involving co-residents.

There is no evidence of an interdisciplinary assessment of responsive behaviours on the medical record. Interview with a Registered Nurse was unable to identify where or how an interdisciplinary assessment had occurred.

There is no evidence of an interdisciplinary assessment of the behaviours exhibited by a specified resident within the medical record.
Behaviours exhibited are not addressed in the plan of care, triggers are not identified and interventions to prevent similar incidents are not included in the plan of care.
The Registered Nurse interviewed was unable to demonstrate how an assessment had been conducted related to behaviours, their triggers or a variation in the resident's functioning at different times of the day.

Inspector ID #:	Nursing Inspector #192

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #7: The Licensee has failed to comply with O. Reg. 79/10 s. 52(2)

Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Findings:

A specified resident was hospitalized following injury. No pain assessment was completed on return to the home. There is no evidence of a pain assessment in the medical record, or in the computerized

documentation on Point Click Care. The registered nurse was asked for the pain assessment but was unable to locate an assessment in the medical records or after consultation with the RAI MDS Coordinator.

During observation the resident was able to communicate clearly the presence of pain. The resident was observed ambulating in the hall and was noted to be in pain.

The flow sheet between March 1 -17 was noted to include documentation from the Personal Support Worker's that the specified resident has pain each shift.

Inspector ID #:	Nursing Inspector #192

WN #8: The Licensee has failed to comply with O. Reg. 79/10 s. 54(b)

Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

Findings:

The home has failed to minimize the risk of altercations and potentially harmful interactions between residents as evidenced by the ongoing incidence of aggression toward co-residents by a specified resident. Interventions have not been identified as ineffective and the plan of care updated.

The home has not involved the specialized help of the Pieces Resource Consultant or geriatric assessment even though a specified resident has exhibited aggression toward residents and staff. Residents of the home area remain at risk.

The potential for physical aggression is not identified on the plan of care for a specified resident. No interventions are included to minimize the risk of altercations and potentially harmful interactions between residents.

Inspector ID #:	Nursing Inspector #192

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, ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including , identifying and implementing interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O. Reg. 79/10 s. 8(1)(b)

Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with all applicable requirements under the Act; and
(b) is complied with.

Findings:

1. The homes policy on Management of Aggressive Resident Behaviour (LTC-P-110) indicates that a psychiatric evaluation should be completed. A specified resident has not has a psychiatric evaluation in spite of multiple episodes of aggression toward co-residents.

2. The homes policy on Management of Aggressive Resident Behaviour (LTC-P-110) indicates that the reason for the resident's anger should be investigated. Flow sheets indicate that a specified resident demonstrated persistent responsive behaviour with self or others. There is no documentation to support that anyone spoke to the resident or investigated the cause of the responsive behaviour exhibited.

3. The homes Pain Assessment and Symptom Management Program (LTC-N-45 and its components) require that pain assessment tools will be utilized for the assessment of residents with pain. No pain assessments were completed for a specified resident, with changes in medication, in spite of documentation from the physiotherapist that the resident was in severe pain, or with the development of a pressure ulcer.

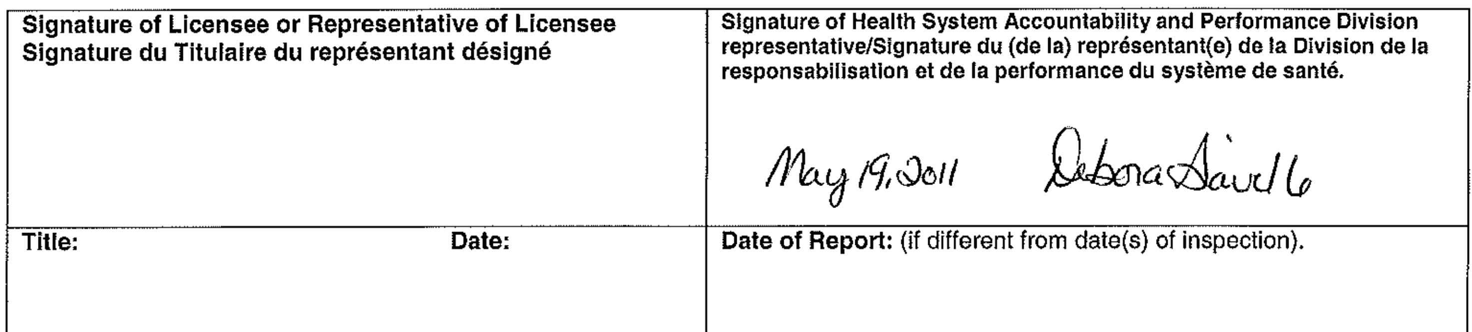
4. The homes Fall Interventions Risk Management Program (LTC-N-75) requires that all residents be assessed by an interdisciplinary team with any identified change in the Resident's health status and/or readmission from hospital. No fall risk assessment was completed for a specified resident on return from hospital.

5. The homes Fall Interventions Risk Management Program (LTC-N-75) requires that if a fall has occurred, a resident fall documentation form (LTC-N-75-10) will be completed and will be kept with the multidisciplinary progress notes. No resident fall documentation forms were completed for a specified resident following documented falls.

Inspector ID #:	Nursing Inspector #192

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 ensuring that the identified policies (Falls, Pain, Management of Aggressive Resident Behaviour are complied with, to be implemented voluntarily.



Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** May 19, 2011 Debora Saville
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**		
Name of Inspector:	Debora Saville	**Inspector ID #**	192
Log #:	H - 00528		
Inspection Report #:	2011_192_2849_16Mar205803		
Type of Inspection:	Critical Incident		
Date of Inspection:	March 17 & 18, 2011		
Licensee:	Revera Long Term Care Inc. 55 Standish Court, 8th Floor, Mississauga ON, L5R 4B2		
LTC Home:	Ridgeview Long Term Care Centre, 385 Highland Road West, Stoney Creek ON L8J 3X9		
Name of Administrator:	Anne D'Ambrosio		

To Revera Long Term Care Inc., you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(2)

The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Order:

The licensee will immediately complete comprehensive, interdisciplinary assessments related to pain management, falls prevention and the safe use of bed rails for a specified resident, ensuring comfort and safety and will ensure that all staff responsible for care are aware of the results of the assessment and interventions to promote comfort and safety.

Grounds:

1. A specified resident had a surgical intervention and has acquired a wound. Documentation on the progress notes indicates that the resident's pain is not well controlled. On interview the resident indicated that there was pain. The resident's activities of daily living are impacted by the pain. No pain assessment was completed as evidenced by a review of the medical record, point click care and in discussion with the Registered Practical Nurse.

2. A specified resident was noted to have one bed rail in the up position, it was indicated during interview that this is the resident's preference. The flow sheet for the resident indicates that two bed rails are consistently in place. There is no indication in the medical record that an assessment has been completed to determine the resident's safety and use of bed rails. There is no bed rail use indicated in the plan of care.

3. A specified resident had a fall risk assessment tool completed, sustained a fall with injury and a fall that resulted in transfer to hospital. No fall risk assessments had been completed following the documented falls or with ongoing documentation related to activities that put the resident at risk of further falls.

This order must be complied with by:	Immediately

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg. 79/10 s. 26(3)5

A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Order:

The licensee will immediately conduct an interdisciplinary assessment for a specified residents related to responsive behaviours, potential behavioural triggers and variations in functioning at different times of the day, ensuring that the plan of care is updated and all staff members are made aware of the contents of the plan of care and interventions to minimize risk to this resident and other residents in the home.

Grounds:

The progress notes indicate that a specified resident was involved in numerous episodes of responsive behaviours involving co-residents.

There is no evidence of an interdisciplinary assessment of responsive behaviours on the medical record. Interview with a Registered Nurse was unable to identify where or how an interdisciplinary assessment had occurred.

There is no evidence of an interdisciplinary assessment of the behaviours exhibited by a specified resident within the medical record. Behaviours exhibited are not addressed in the plan of care, triggers are not identified and interventions to prevent similar incidents are not included in the plan of care. The Registered Nurse interviewed was unable to demonstrate how an assessment had been conducted related to behaviours, their triggers or a variation in the resident's functioning at different times of the day.	
This order must be complied with by:	Immediately

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

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 was served on the Licensee.

The written request for review must include,

(a) the portions of the order 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 or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Issued on this 19th day of May , 2011.	
Signature of Inspector:	Debora Saville
Name of Inspector:	Debora Saville
Service Area Office:	Hamilton Service Area Office Ministry of Health and Long Term Care Performance Improvement and Compliance Branch 119 King St. West, 11th Floor Hamilton, ON, L8P 4Y7