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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 4, 2015	2015_265526_0004	H-001904-15	Complaint

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

THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 24, 25, and 26, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator,Continuous Quality Improvement Manager (CQIM), Registered Staff, personal support workers (PSWs), residents, and families.

During the course of the inspection, the inspector toured home areas, observed resident care, and reviewed clinical records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Minimizing of Restraining
Pain

During the course of this inspection, Non-Compliances were issued.
- **4 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 written plan of care set out clear directions to staff and others who provided direct care to a resident.

Resident #100's admission RAI MDS assessment completed during a month in 2014 indicated that the resident was usually continent of bowel and bladder and used an incontinence brief or pad. Review of the health record indicated that after admission, the resident had a deterioration in continence with associated altered skin integrity.

Approximately seven weeks after the admission to the home, resident #100 was admitted

to hospital for two weeks with bowel, bladder and other health issues. Upon return to the home, the physician's order sheet indicated that the resident required treatments for bladder management. The resident's electronic treatment administration record (eTAR) indicated that, during 18 days following discharge from hospital, the resident received this treatment one time on 12 days, two times on two days and three times on one day. Registered staff confirmed that the resident received the treatment as needed and not every shift. However, during interview, non registered staff stated that registered staff would provide the treatment to the resident once each shift.

The document the home referred to as the resident's "care plan" last updated 10 days after discharge from hospital, and the associated Kardex used by direct care staff did not include planned care regarding the resident's bladder management. This was confirmed by registered staff. The registered staff also confirmed that non registered direct care staff did not have clear direction regarding the management of resident #100's bowel and bladder. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) Resident #100's admission RAI MDS assessment completed during a month in 2014 indicated that the resident was usually continent of bowel and bladder and used an incontinence brief or pad. The Admission Continence Assessment indicated that resident #100 was continent and did not use briefs. The RPN and RAI Coordinator confirmed that these assessments were not consistent with each other.

B) Resident #100's Quarterly Continence Assessment conducted three months after admission indicated that the resident was incontinent and used liners. Non registered and registered staff stated that the resident currently used pull ups. Registered staff confirmed that the assessments were not consistent with each other. [s. 6. (4) (a)]

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

Admission orders for residents #100 and #200 included a bowel protocol that directed staff to do the following if the resident had not had a bowel movement (BM):

i) no BM on day 2: give prune juice and fruit lax with breakfast;

ii) no BM on day 3: give milk of magnesia suspension 15-30ml by mouth as needed for constipation
iii) no BM on day 4: Bisacodyl (Ducolax) 10mg suppository insert rectally at 0600 hours

A) Resident #100 was admitted to the home during a month in 2014. Interview with resident #100's POA indicated that the resident was experiencing constipation shortly after the resident's admission into the home and was holding their stomach, grimacing and oozing feces into a brief on numerous occasions. Review of the health record indicated the resident had responsive behaviours related to bowel movements. During interview with the LTC Inspector, the Behaviour Support Ontario (BSO) resource staff stated that the resident's continence management may have been contributing to responsive behaviours.

Approximately seven weeks after admission to the home, the resident was admitted to hospital for bowel, bladder and other health issues. Review of resident #100's health record between admission to the home and admission to hospital, revealed that the resident had multiple episodes of constipation and had not received interventions as described in the bowel protocol. Review of progress notes following return to the home from hospital indicated that a primary goal for the resident was to prevent future constipation. However, health records indicated that the resident did not receive treatment for a further episode of constipation according to the plan of care. Registered staff and the DOC confirmed that care had not been provided for resident #100 according to the plan of care/bowel protocol.

B) Review of resident #200's health record indicated that the resident had constipation on two occasions during two months in 2015. The resident's eMAR indicated that the bowel protocol had not been initiated for the first episode, and during the second episode, the resident did not receive an intervention for constipation until the fifth day of no BM. The resident was admitted to hospital and had surgery for bowel related issues. A Registered Nurse confirmed that resident #200 had not received care according to their plan of care/bowel protocol. [s. 6. (7)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #100 was admitted to the home during a month in 2014. The resident's admission RAI MDS assessment indicated that the resident was usually continent of

bowel and bladder and used an incontinence brief or pad. Interview with staff revealed that the resident became incontinent after the initial admission assessment. Review of resident #100's health record indicated that, during three months following admission, the resident was incontinent of bowel during 37 documented shifts and incontinent of bladder during 88 documented shifts. The resident's Power of Attorney (POA) reported that they found the resident's clothing had become wet/soiled due to incontinence. Progress notes indicated that the resident had developed altered skin integrity due to incontinence, and the resident demonstrated responsive behaviours related to incontinence. Interview with the Behavioural Support Ontario (BSO) staff person,BSO documentation in the health record and documented of the resident's care conference included recommendations to initiate a toileting schedule/programme.

Approximately seven weeks following admission to the home, resident #100 was admitted to hospital for two weeks with bowel and bladder health issues that required interventions. Upon return to the home, the resident required treatments to for bladder management including the initiation of a toileting programme. However, review of the document the home referred to as resident #100's "care plan" updated following hospitalization, indicated that the resident was continent and staff were to offer toileting upon request during waking hours; the care plan did not indicate that the resident was receiving bladder management treatments or a toileting programme.

On February 24, 2015, during interview with registered staff, it was confirmed that the staff had not initiated a toileting schedule or programme for resident #100 and that the plan of care was not updated to reflect that the resident was receiving bladder related treatments. Registered staff and the DOC confirmed that that the resident's plan of care had not been updated when the resident's care needs changed. [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 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 [s. 6(1)c]; that the care set out in the plan of care is provided to the resident as specified in the plan [s. 6(7)]; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change [s. 6(10)b], to be implemented voluntarily.

WN #2: 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 failed to ensure that a resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, that was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #100 was admitted to the home during a month in 2014. The resident’s admission RAI MDS assessment indicated that they were usually continent of bowel and bladder and used an incontinence brief or pad. The home’s Continence Assessment conducted on admission indicated that the resident was continent. However, review of their health record indicated that, during three months following admission, the resident was incontinent of bowel during 37 documented shifts and incontinent of bladder during 88 documented shifts.

Registered staff confirmed that resident #100 had increased incontinence following admission and was not usually continent. The POA reported to the Long Term Care Homes (LTC) Inspector that the resident’s clothing had become wet/soiled due to incontinence. Progress notes indicated that the resident had developed excoriation due to incontinence, and demonstrated responsive behaviours related to incontinence. During interview, the Behavioural Support Ontario (BSO) resource staff suggested that the resident's incontinence and altered skin integrity may have been contributing to their responsive behaviours. Approximately seven weeks following admission, the resident was hospitalized for urinary retention, UTI, constipation, and other health conditions. They received treatment and returned to the home approximately two weeks later.

Resident #100's health record did not include an assessment of their continence in terms of causal factors, patterns, type of incontinence and potential to restore function when the resident’s continence level deteriorated after admission, or upon return from hospital. Registered staff and the DOC confirmed this. [s. 51. (2) (a)]

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

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. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #100's RAI MDS admission assessment completed during a month in 2014, indicated that the resident experienced mild pain daily and was not receiving analgesia. The document the home referred to as the resident's "care plan" completed two weeks later directed staff to assess the resident's pain "using an appropriate monitoring tool (PAINAD)".

Review of progress notes indicated that resident #100 had experienced pain requiring analgesia as needed (PRN) during the month following admission. Five weeks after admission, progress notes indicated that the resident was sleeping poorly, was irritable, and that these behaviours may have been pain related. Progress notes also indicated that the resident was complaining of pain upon urination; at that time, a regularly scheduled analgesia was ordered to manage the resident's pain.

Approximately six weeks after admission to the home, the resident was observed to be grimacing, holding their abdomen, doubled over in pain, and collapsed as the result of pain. Approximately seven weeks following admission, the resident was admitted to hospital with bowel, bladder, and other health issues requiring interventions and returned to the home approximately two weeks later.

Review of the resident's health record indicated that the resident's pain had not been assessed using an appropriate monitoring tool as specified by the home between admission to the home and two weeks following discharge from hospital. The RN in the home area confirmed this. The DOC confirmed that the resident's pain should have been assessed with a monitoring tool as per the home's policy. [s. 52. (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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of bedrails as a personal assistance services device (PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following were satisfied:

i) Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.

ii) The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.

iii) The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations.

iv) The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

A) Review of resident #100's health record indicated that the resident's POA requested that bed rails be used for the resident. On February 24 and 25, 2015, two one half bed rails were observed in the up position of the resident's bed; staff confirmed that the resident used the rails for bed mobility and to assist them to get up and out of bed independently.

Review of the health record indicated that the resident had not been assessed for the use of the bed rails as a PASD as the most appropriate device given their health condition, and there was no consent for their use in the health record. Registered staff confirmed that resident #100 had not been assessed for the use of bed rails as a PASD, and that they had a history of falls and confusion; staff told the LTC Inspector that the rails may actually increase the risk of fall for the resident.

B) Review of resident #200's health record indicated that the resident had two one half bed rails in the up position to assist the resident with bed mobility. On February 26, 2015,

LTC inspector observed the resident's bed rails in the up position. PSW staff and the RAI Coordinator confirmed that the resident used bed rails to assist with bed mobility while in bed since admission to the home in 2013. Review of the resident’s health record indicated that they had not been assessed for the use of the bed rails as a PASD as the most appropriate device given their health condition, alternatives had not been considered, and there was no consent for bed rail use in the resident’s health record. Registered staff and the RAI coordinator confirmed this.

During interview, the DOC confirmed that bed rails used by residents to assist with mobility were considered to be PASD's. The DOC confirmed that residents should have been assessed for bed rail appropriateness given a resident’s health condition, should be the least restrictive device, and that consent should have been obtained for their use. [s. 33. (4)]

Issued on this 5th day of May, 2015

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

Original report signed by the inspector.