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

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date June 21, 2022
Inspection Number 2022_1246_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Revera Long Term Care Inc

Long-Term Care Home and City
Riverbend Place, Cambridge

Lead Inspector
Janis Shkilnyk (706119)

Choose an item.

Additional Inspector(s)
Elaina Tso (741750) was present for the inspection

Janis M Shkilnyk

Digitally signed by Janis M Shkilnyk
Date: 2022.07.04 09:52:32 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): May 30 – June 3 and June 7-9, 2022

The following intake(s) were inspected:

- Log #: 008231-22 Complaint related to care concerns for a resident.
- Log #: 007912-22 Critical Incident related to an unexpected death

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Safe and Secure Home
- Skin and Wound Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION - REPORTING CERTAIN MATTERS TO DIRECTOR

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NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: FLTCA, 2021, s. 28 (1) (2)

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, immediately report the suspicion and the information upon which it was based to the Director: 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.

Rationale and Summary

Progress notes documented an allegation of abuse to a resident. This allegation was reported to management. Individuals attending a conference at the home related to the resident's care, alleged injuries had occurred to the resident while at the home.

A review of the Ministry of Long-Term Care (MLTC) Critical Incident (CI) reporting system showed that there were no allegations of abuse in relation to the resident reported to the Director during the time identified.

The home's failure to report to the Director immediately after becoming aware of allegations of abuse for the resident, may have delayed the Director's ability to respond to the incident in a timely manner.

Sources:

record review of resident, progress note review, Critical Incident Reporting System review

[#706119]

WRITTEN NOTIFICATION – GENERAL REQUIREMENTS

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 34 (2)

The licensee has failed to comply with the documentation of the head injury routine reassessment for resident #001 post fall.

In accordance with O. Reg 246/22 s. 11. (1) (b), 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.

Specifically, the staff did not comply with the licensee's policy RET-Head Injury Routine, CARE5-010.5, reviewed date: March 31, 2022, which was captured in the home's Fall Prevention and Management Program. The policy outlines the requirements for completion of the Neurological Flow Sheet/Head Injury Routine.

Rationale and Summary

A Registered Nurse (RN) confirmed that when a resident experiences an unwitnessed fall a head injury routine is initiated. The neurological flow sheet is to be completed per the schedule outlined on the form. A RN verified that if a resident was sleeping, the home's expectation was to wake the resident to complete neurological flow sheet.

A resident had an unwitnessed fall. The neurological flow sheet was to document eye opening, motor response, verbal response and vital signs every one hour, for six hours. There was no documentation of blood pressure five of the six checks. The head injury routine assessment was not documented on one occasion for the resident.

Policy RET-Head Injury Routine, CARE5-010.5, reviewed date: March 31, 2022, states the nurse is to complete the Neurological Flowsheet and follow the frequency of observation as per the Neurological Flowsheet or as determined by Physician or regional requirement. The Neurological Flowsheet references on the back of the form the Glasgow Coma Scale and to continue Glasgow Coma Scale assessments as per Head Injury Tool.

The home's failure to complete the neurological flow sheet for a resident risked a delay in treatment and potential worsening of a head injury for the resident.

Sources:

Interviews with Executive Director, Registered Nurse, record review of the resident, Neurological Flow Sheet for the resident, progress note review, policy-RET-Head Injury Routine, CARE5-010.5, Reviewed Date: March 31. 2022.

[#706119]

WRITTEN NOTIFICATION - INFECTION PREVENTION AND CONTROL PROGRAM

NC#03 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (11) (a) (b)

The licensee has failed to comply with communicating of an outbreak to the public by posting an outbreak notification sign at the entrance of the home.

In accordance with O. Reg 246/22 s. 11 (1) b, the licensee is required to ensure the infection prevention and control program, has in place an outbreak management system, including communication plans, and it must be complied with.

Specifically, staff did not comply with the home's policy Outbreak Management Protocols, IPC7-010.01, reviewed date-March 31, 2022, which refers to the outbreak roles and responsibilities checklist. The outbreak roles and responsibility checklist for the Infection Control Coordinator (or designate) under outbreak declared, states that an outbreak notification sign at the entrance of the home for public awareness of the outbreak.

Rationale and Summary

On May 17, 2022, the home was declared to be in an acute respiratory illness outbreak. The front entrance door did not have signage posted indicating the home was in a declared outbreak for an infectious disease. On May 30, 2022, the home continued to experience an acute respiratory illness outbreak.

A housekeeper stated they did not think the home was currently experiencing an infectious outbreak.

A Registered Practical Nurse (RPN) stated that the home was not in an outbreak.

The Executive Director confirmed that signage posted at the entrance into the home did not indicate a current outbreak for acute respiratory infection.

The home's failure to post entrance door signage indicating the home was experiencing an infectious outbreak could have led to potential risk related to further spread of infection by not communicating clear direction for those entering.

Sources:

Interviews with Executive Director, Registered Practical Nurse (RPN), housekeeper, policy-Outbreak Management Protocols, IPC7-010.01, reviewed March 31, 2022.

[#706119]

WRITTEN NOTIFICATION - INFECTION PREVENTION AND CONTROL PROGRAM

NC#04 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (2) (b)

The licensee has failed to comply with signage, listing the required infection control precautions at the entrance to a resident's room or bed space. Provincial Infectious Diseases Advisory Committee (PIDAC): Routine Practices and Additional Precautions in All Health Care Settings | November 2012, states signage specific to the type(s) of additional precautions should be posted: A sign that lists the required precautions should be posted at the entrance to the client/patient/resident's room or bed space.

Rationale and Summary

A resident had a diagnosis of an infectious disease.

Signage outside of a resident's door had "stop" on it and directions to check with the nursing station. No other signage was observed on the resident's bedroom door. Personal protective equipment was available prior to entering the room. No precaution signage was observed on a resident's bedroom door.

A Personal Support Worker (PSW) stated they were unsure what type of isolation the resident required.

A Registered Nurse (RN) stated the resident had recently been on a different type of precaution. They remained on another type of precaution. That signage had not been changed on the door.

The resident's plan of care documented that additional precautions were to be followed in relation to an infectious disease.

The home's failure to post signage on the resident's bedroom door with specific additional precautions for the resident posed a risk that staff would not follow appropriate precautions for the infectious disease.

Sources:

Interviews with Registered Nurse (RN), Personal Support Worker (PSW), review of resident's care plan, PIDAC: Routine Practices and Additional Precautions in All Health Care Settings, November 2012.

[#706119]

WRITTEN NOTIFICATION – MEDICATION MANAGEMENT SYSTEM

NC#05 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 123 (1)

The licensee has failed to comply with safe medication management and optimized effective drug therapy outcomes for a resident when medication reconciliation was not completed.

In accordance with O. Reg 246/22 s. 11. (1) (b), 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.

Specifically, the staff did not comply with the licensee's policy, LTC-Medication Reconciliation, CARE13-010.02, review date: March 31, 2022, Medication Reconciliation – Move In, which stated that the Nurse would complete an accurate Best Possible Medication History (BPMH) of the resident's medication, including name, dose rate, the frequency and corresponding diagnosis. This would include, but not be limited to: A systematic process of interviewing the Resident/Substitute Decision Maker (SDM) and a review of at least one other reliable source of information.

The licensee has failed to ensure that when a resident was admitted to the home the resident/substitute decision maker was interviewed in order to complete an accurate Best Possible Medication History (BPMH) medication reconciliation.

Rationale and Summary

A resident was admitted to the home. The Nurse Practitioner (NP) reviewed the home's process for admission medication orders for new residents. The NP confirmed that the admission nurse obtained a medication list for a resident from their community pharmacy prior to the resident being admitted to the home. This list was reviewed the day before the resident was admitted to the home by the admission nurse with the NP. Medications for the resident were ordered by the NP, the day before the resident was admitted to the home. The NP stated that if there were questions, these were discussed with the nurse.

The Registered Nurse (RN) confirmed that the resident's community pharmacy medication list was not reviewed with the resident's substitute decision maker prior to obtaining admission medication orders from the NP. The RN stated that as the resident's substitute decision maker (SDM) showed the RN medication bottles from the resident. The RN then showed the SDM the community pharmacy medication list sent to the home by the pharmacy. The SDM wrote corrections on the list. The SDM requested a different medication time and dose for the specific medication than what was listed. The SDM explained they were giving the specific medication differently to the resident at home, as they found it helpful with the resident's evening responsive behaviors. The SDM also requested that the resident be given another medication that was not listed on the community pharmacy list.

Progress notes documented that the resident's SDM stated that the resident experienced responsive behaviors in the evening, and the specific medication was given at a specific time and helped the resident with these behaviors. Documentation showed the SDM had concerns with two other medications ordered on admission for the resident.

Progress notes documented several concerns brought forth by the SDM related to timing of the specific medication being given to the resident and the SDM's concern about the effect this was having on the resident's evening responsive behaviors.

The home's failure to interview the resident's substitute decision maker related to medication reconciliation may have contributed to increased responsive behaviors exhibited by the resident.

Sources:

Interviews with Executive Director, Nurse Practitioner, Registered Nurse, record review for the resident, progress notes, policy-LTC-Medication Reconciliation, CARE13-010.02, review date March 31, 2022.

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WRITTEN NOTIFICATION – SKIN AND WOUND CARE

NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 55 (2) (b) (i)

The licensee has failed to ensure that when a resident had documented alteration in skin integrity, that they received a skin assessment by a member of the registered nursing staff,

using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Rationale and Summary

Progress notes for a resident documented an alteration in skin integrity. No skin assessment was documented for the resident.

A Registered Nurse confirmed that when becoming aware of an alteration in skin integrity for a resident, a skin and wound evaluation is to be completed immediately. The RN confirmed that a skin assessment had not been completed for the resident when an alternation in skin integrity had been identified and documented.

The home's failure to complete a skin and wound assessment for the resident could have impacted treatment and thus the healing of the skin concern.

Sources:

Interview with Executive Director, Registered Nurse, record review of the resident, review of assessments in point click care, policy-LTC-Skin and Wound Care Program, Review Date: March 31, 2022.

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