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 # / Registre no	Type of Inspection / Genre d'inspection
Dec 13, 2016	2016_414110_0009	027419-16	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

SARA VISTA
27 SIMCOE STREET ELMVALE ON L0L 1P0

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

DIANE BROWN (110), JANET GROUX (606)

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): September 8, 9, 12, 13, 14, 15, 16, 19, 20, 2016.

The following intakes were inspected concurrently with the Resident Quality Inspection (RQI):
Complaint log #001440-14 related to care not provided.
Critical incident (CI) log #025577-16 related to resident elopement.

During the course of the inspection, the inspector(s) spoke with executive director/director of care (ED), the assistant director of care, attending physician, program manager, environmental services manager, registered nurses, registered practical nurses, personal support workers, representative of Residents' Council, residents, families and a resident's substitute decision-maker (SDM)

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 a written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

On an identified date, resident #005's bed was observed with two quarter bed rails, one on each side, in the up position, at the head of the resident's bed.

Staff interviews with PSW #112 and #104 identified the resident used the two quarter bed rails, one on each side, at the head of the bed, for repositioning and bed mobility.

Interview with RPN #103 identified that the resident used one quarter bed rail, at the head of the bed for safety, when in bed, as he/she was not mobile at all.

Staff interviews including the ADOC confirmed that the resident kardex is used to communicate care to front line staff for each resident.

Record review of resident #005's kardex did not identify the use of bed rails. A review of the resident's written plan of care identified that the resident prefers his/her quarter rails, in the middle of the bed, to be engaged at all times, during all three shifts and for staff to provide total assistance for bed mobility.

The ADOC confirmed that resident #005's plan of care did not set out clear directions to staff and others around the use, location and purpose of the bed rails. [s. 6. (1) (c)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

Record review of resident #003's minimum data set (MDS) assessment on an identified date, indicated that the resident had a worsening area of skin integrity, located on an identified area.

Review of the plan of care initiated prior to the identified MDS assessment date, and revised after the MDS assessment date, indicated resident #003 had two identified areas of skin integrity since returning from the hospital. Review of the plan of care revealed directions to staff to refer to the electronic treatment administration record (eTAR) for the current treatment plan.

Review of resident #003's eTAR for an identified month after returning to the home, revealed that staff were to monitor resident's identified area of skin integrity for three days and document in the eTAR and that the resident was to wear a device at all times. Further review of the eTAR revealed staff did not document that the above care was provided for 10 days in the identified month.

Interviews with RPN #100, #102, RN #103, and ADOC confirmed it was the expectation of the home that care must be documented by signing in the eTAR. [s. 6. (9) 1.]

3. . 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 and when the resident's care needs change.

Review of a complaint submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2014, reported concerns regarding the home's clinical assessment protocols not being followed.

Review of resident #006's progress notes on an identified date in 2013, resident was observed to have an altered state of health.

The physician was notified and resident #006 was transferred to the hospital. Further record review indicated the resident returned from the hospital accompanied by his/her SDM with a prescription for an identified medication. The SDM indicated the hospital did not send any documentation and informed the home the hospital believed resident #006 had an identified medical concern. The progress notes further revealed the SDM had inquired whether the home had completed a swallowing assessment due to resident's change of condition.

Later on an identified date, it was documented that resident #006 condition remained declined.

Review of a communication letter from the home to the physician dated seven days later on an indentified date in 2013, revealed a request for a Speech Language Pathology (SLP) referral for resident #006. The physician ordered a SPL referral a day later. A SLP assessment was completed eight days after it had been ordered and indicated resident had "difficulty pocketing foods, decreased eating, and coughing with fluids" the past week but had been improving. A day following the SLP assessment the progress notes indicated resident passed away.

Interview with the SDM revealed he/she had asked the home, when resident #006 returned from the hospital on an identified date in 2013 for a swallowing assessment.

Interview with the RPN #101 and ADOC revealed the home initiated a referral for an SLP assessment but the dietician was not able to conduct resident #006's SLP assessment until later, the day before resident #006 passed away. [s. 6. (10) (b)]

4. The licensee has failed to 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 the resident's care needs change or care set out in the plan is no longer necessary.

Review of an identified complaint submitted to the Ministry of Health, indicated resident #006 was diagnosed with an identified medical concern and the complainant alleged the home did not follow up appropriately.

Review of a Georgina Bay General Hospital Laboratory Results report, indicated resident #006 had an identified medical concern.
Review of resident #006's relevant plan of care, in place, did not indicate any plan of care to direct staff to manage the resident's medical concern.

Interview with the SDM revealed he/she had requested information regarding management of medical concern, but did not receive any information from the home. He/she indicated that the home did not provide any measures to manage the identified medical concern.

Interviews with the Physician, PSW #104, RPN #100, #102, RN #101, and the ADOC revealed the resident was positive for the identified medical concern and the home's protocol was to initiate procedures. Further interview with PSW #104, RPN #100, #102, and RN #101, and the ADOC indicated what procedures would have been required for the identified medical concern.

Interview with RN #101 and the ADOC confirmed the plan of care did not indicate a plan of care to manage resident #006's identified medical concern. [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 ensure that a written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident and that the resident reassessed and the plan of care reviewed and revised at least every six months and at any other time and when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

The inspector, RPN #100, administrator, and the ESM observed on September 8, 2016, at 0945 hrs, the east end door leading from the hallway into a small vestibule to another door leading to the outside (this door to the outside does not lock from inside) would not engage into the strike plate of the door resulting in the door not closing and locking.

Interview with RPN #100 revealed the second door lead outside to the back of the building and is restricted from being used by residents. They further revealed the first door is usually locked to ensure that residents do not have access to this area and confirmed it was not locking at this time.

Interview with the ESM and the administrator indicated that all doors are checked daily during the ESM's morning walkabout. The ESM stated he/she checked earlier that morning and found this door was locking properly and did not observe any issues. Further interview with the ESM stated that the door may not have completely closed because of the air pressure build up between the first and exit door. He/she indicated he/she would check the door to ensure that it does not happen again. [s. 9. (1) 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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) 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. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care must be based on, at a minimum, interdisciplinary assessment of residents 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.

Review of Critical Incident (CI) # 2710-000010-16 reported that on an identified date resident #013 was missing and had exited the home for a five minute time period. Further record review revealed that PSW #112 and RPN #115 were on duty and identified the resident was missing.

Interview with PSW #112 revealed that resident #013 was known to have exit seeking behaviours and on the evening of the elopement he/she knew the resident was existing seeking as the resident was shaking the locked front door. The PSW stated he/she left to go attend to something, came back and realized the resident was not at the door and the door was unlocked. The PSW continued stating that he/she looked outside and the resident was down by the end of the driveway.

Staff interview with RPN #115 revealed that resident #013 had exit seeking behaviours and the evening of the elopement, the resident exited the building when the residents, who were outside smoking, returned back into the home.
Interviews with PSW #104, #113 and RPN #100 identified the resident with exit seeking behaviours.

Record review of resident #013's health record progress notes, approximately seven

months up to the date of the elopement, identified seven prior incidents of exit seeking behaviours.

Record review of the MDS quarterly assessment approximately two months prior to the elopement failed to identify resident #013's wandering or exit seeking behaviours.

Record review of the resident's plan of care, dated two months prior, failed to identify resident's wandering and exit seeking behaviour.

The ADOC confirmed resident #013's plan of care did not identify his/her wandering behaviours; potential behavioural triggers and any variations in resident functioning at different times of the day prior to the elopement incident. [s. 26. (3) 5.]

2. The licensee failed to ensure the plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident's safety risks.

Review of CI # 2710-000010-16 reported that on an identified date, resident #013 was missing and had exited the home for a five minute time period. Further record review revealed that PSW #112 and RPN #115 were working and identified that the resident was missing.

Interview with PSW #112 revealed that resident #013 had exit seeking behaviours and the evening of the elopement, he/she knew the resident was existing seeking as he/she was shaking the locked front door. The PSW stated he/she left to go attend to something, came back and realized the resident was not at the door and the door was unlocked. The PSW continued stating that he/she looked outside and the resident was down by the end of the driveway. PSW #112 stated that a few residents who smoke have specific times outside and they were outside. He/she stated that resident #013 probably got out when the smoking residents exited or returned to the home. The resident returned to the home, uninjured with PSW #112.

Interview with RPN #115 revealed that on the evening of the identified date, resident #013 had exit seeking behaviours and exited the building when the residents who were outside smoking returned back into the home. RPN #115 stated that he/she thought a resident pushed the button, the door automatically opened and resident #013 left. RPN #115 stated resident #013 made it as far as the stop sign at the bottom of the drive way on Simcoe Street. RPN #115 confirmed that the door was not locked at the nurse's station which deactivates the red push button for the front door.

Staff interview with RPN #100 stated that resident #013 does have exit seeking behaviours and will hang around the front door. He/he also revealed that most times they lock the front door in the evenings and by locking the door at the nurses station it deactivates the red push button causing visitors and those residents who smoke outside to ring the bell to enter the home.

Record review of resident #013's health record, process notes for approximately seven months prior to the elopement identified seven prior incidents of exit seeking behaviours.

Record review of the MDS quarterly assessment dated approximately two months prior to the elopement failed to identify resident #013's wandering or exit seeking behaviours and safety risk.

Record review of the resident's plan of care dated approximately two months prior to the elopement failed to identify resident's wandering; exit seeking behaviour and subsequent safety risk.

Interview with RN/RAI coordinator identified that resident #013 had wandering behaviours and that the behaviour was a safety concern when the resident was looking for an exit as the resident could wander out and he/she was unsteady on his/her feet. The RN/ RAI coordinator confirmed that staff do lock the door at the nurses station, deactivating the push button. The coordinator further confirmed that the resident's plan of care prior to the elopement incident did not address resident #013's safety issue of elopement and the need for staff to lock the front door.

Interview with ADOC confirmed that resident #013 does have exit seeking behaviour and that it was a safety concern as the resident could get out and he/she would not know where he/she was going. The ADOC further stated the resident's gait was very unsteady for outside, that the resident just wanted to go home and if outside he/she would not know how to get back .

The ADOC confirmed that the resident's plan of care was not based on the resident's safety risk of exit seeking and eloping prior to the incident when the resident eloped. [s. 26. (3) 19.]

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 the plan of care must be based on, at a minimum, interdisciplinary assessment of residents 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, to be implemented voluntarily.

WN #4: 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 failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Review of a complaint submitted to the Ministry of Health on an identified date, indicated a medication error occurred when a medication was abruptly discontinued for resident #006.

Review of resident #006's progress notes revealed he/she was readmitted from the hospital on an identified date with a change in the dosage of the medication. Interview with the physician and RN #100 confirmed a medication error was made regarding the above medication. They indicated the medication was discontinued rather than the dosage being changed.

Interviews with RPN #100, RN #100, the ADOC, and the ED revealed the home's practice was to complete a medication incident report with detailed information and follow up of the incident. The ED confirmed the home was not able to locate the medication incident report. [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 is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #5: 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 failed to ensure the right of residents to 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 fully respected and promoted.

The inspector observed on September 8, 2016, at 0935 hrs the Point of Care (POC) monitor located on a wall by room #101, displaying resident #007's personal health information

Interview with PSW # 110 revealed he/she had forgotten to log off and close the POC monitor before leaving the area and confirmed the home's expectation is for staff to log out of the POC monitor and close the screen. He/she logged off and closed the screen once the concern was raised by Inspector #606. [s. 3. (1) 11.]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.