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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 28, 2017	2017_680687_0012	026449-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

LOVIRIZA CALUZA (687), STEPHANIE DONI (681)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 11 to 15, 2017.

A complaint log was submitted to the Director related to staff to resident medication incident and was inspected during this RQI.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Recreation Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and the Substitute Decision-Maker (SDM).

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health records, staffing schedules, internal investigations, policies, procedures, programs, and program evaluation records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the Director which alleged that resident #006 had received a medication from the home without consent from the SDM.

A record review of the nurses' progress notes indicated that resident #006 was seen by the physician and was prescribed a medication. A review of the nurses' progress notes did not indicate that the SDM was made aware of the new medication ordered by the physician. A record review identified that the physician discussed the medication order with the family on a particular date and indicated the following in their notes: "As per Sara Vista policy, whenever there is a new medication order, the family or SDM is always notified prior to administration of the medication but unfortunately in this instance the SDM was not notified by the staff for reason unknown to me".

A record review of the electronic administration record (EMAR), indicated that resident #006 received the medication on a particular date.

A review of the home's policy titled "Resident Assessment and Plan of Care" revised August 31, 2017, indicated that, "Each resident/SDM will have the opportunity to

participate in the development of their plan of care to address their individual needs and preferences".

In an interview with Inspector #687, the SDM stated that resident #006 was admitted in the home on a particular date. The SDM further stated that the home was advised not to provide any medication unless the home consulted with the SDM due to resident #006's previous medical history.

During an interview with Inspector #687, RPN #111 stated that the staff were not made aware of the family's request not give the specified medication. The RPN further stated that they were unable to recall if they had given the medication in the particular date.

In an interview with Inspector #687, RPN #103 indicated that for any new medication or change of medication or treatment, the registered staff were required to call the family for consent and document the consent in the nurses' progress notes.

In an interview Inspector #687, the DOC stated that for any new medication or treatment, registered staff were expected to notify the resident if competent or notify the family or SDM. The DOC acknowledged that when the medication was ordered by the physician on a certain date, the registered staff did not notify the family or SDM of the new medication order before it was administered. [s. 6. (5)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or when the care set out in the plan was no longer necessary.

Resident #004 was identified as having change in continence through an MDS assessment.

Inspector #681 reviewed the Prompted Voiding/Bowel Program of the resident #004's current electronic care plan, which indicated to refer to the Prevail Resident List for current continence care products. Inspector reviewed the Prevail Resident List, last updated on December 6, 2017, which indicated that the resident was to use a particular continence care product.

In a record review of the home's policy titled "Continence Care: Index # LTC-E-50" last revised May 2013 outlined the following:
- "Residents will have access to a continence care product based on the Resident's

identified needs and personal management".

During an interview with Inspector #681, PSW #107 stated that resident #004's continence had recently changed. PSW #107 stated that resident #004 previously used a specific continence care product but was recently changed. PSW #107 further stated that the Prevail Resident List had not been updated to reflect resident #004's current continence care needs.

During an interview with Inspector #681, the ADOC stated that resident #004's continence care product had been changed, but the Prevail Resident List had not been updated to reflect the change because the staff member responsible for updating the Prevail Resident List was unavailable. The ADOC acknowledged that resident #004's plan of care had not been updated to reflect the changing needs of the resident. [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 resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care as well as to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, 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 has failed to ensure that each 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, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #004 was identified as having worsening incontinence through an MDS assessment.

Inspector #681 reviewed the resident's electronic medical record. No documentation related to resident's change in continence status or change in incontinence product was documented in resident's electronic medical record.

Inspector #681 reviewed the Incontinence Product Change Request form for resident #004 which was completed by PSW #113. The Incontinence Product Change Request form indicated that the reason for a product change request for the resident.

Inspector #681 reviewed the home's policy titled Continence Care – Change of Continence, last updated July 31, 2016, which indicated that a 3-day Continence Diary and a Continence Assessment were to be completed when there was a change in resident's continence status.

During an interview with Inspector #681, PSW #107 stated that resident #004's continence had recently changed. PSW #107 stated that resident #004 previously wore a specific continence care product but that was recently changed. The PSW indicated that

the specific continence care product was not sufficient to meet the resident's needs; as a result of this, a better continence care product was being utilized.

In an interview with Inspector #681, RN #112 stated that continence assessments were completed on admission and if a significant change was identified through an MDS assessment. RN #112 indicated that they did not believe that a change in the type of continence care product being used was reflective of a significant change that warranted a continence assessment. RN #112 further indicated that a continence assessment had not recently been completed for resident #004.

During an interview with Inspector #681, the DOC acknowledged that the home failed to complete a continence assessment for resident #004. [s. 51. (2) (a)]

Issued on this 29th day of December, 2017

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

Original report signed by the inspector.