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
May 29, 2018	2018_742527_0006	003310-18, 004128-18	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

KATHLEEN MILLAR (527)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 10, 11, 13 and 17, 2018.

The Critical Incident System (CIS) that were inspected included:

Log #004128-18, CIS #2710-000003-18 related to outbreak management;
Log #003310-18, CIS #2710-000002-18 related to a resident fall;
Log #009229-17, CIS #2710-000004-17 related to a resident fall; and
Log #002168-17, CIS #2710-000002-17 related to a resident fall.

During the course of the inspection, the Long Term Care Homes (LTCH) Inspector reviewed the clinical records, the home's investigative notes, policies and procedures, meeting minutes and training materials.

During the course of the inspection, the inspector(s) spoke with the Administrator who was also the Director of Care (DOC), the office Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), housekeeping, dietary and program aides, residents' and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **5 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. (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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. 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, (b) the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #010 had a fall with injury and transferred to the hospital for treatment in February 2018. When the resident returned to the home they had a significant change in status.
The licensee's policy called "LTC - Return Assessment from Hospital/Healthcare Centre", index CARE1-010.02, and last reviewed in July 2016, directed staff to update the resident's plan of care to reflect the current assessed care needs.
The clinical record was reviewed and the written plan of care was not updated to reflect the changes when the resident returned from the hospital.
The written plan of care dated December 2017, was provided to the LTCH Inspector #527 by the DOC and they acknowledged that it was the most up-to-date written plan of care. The written plan of care was not reviewed and revised when the resident returned from the hospital to include the falls prevention strategies and activities of daily living (ADLs). There were also interventions related to the resident's change in status that were not added when the plan of care was reviewed and revised. These interventions included positioning, skin and wound care and monitoring and care related to specific equipment.
RN #100 was interviewed and acknowledged that when the resident returned from the

hospital, the registered staff were expected to complete specific assessments, to include but not limited to, a pain assessment, a fall risk screen and a fall assessment, an environmental fall prevention scan, as well as review and revise the written plan of care as needed.
The DOC was interviewed and acknowledged that registered staff were expected to reassess resident #010, and the plan of care reviewed and revised as their care needs had changed. The DOC also acknowledged that some of the resident's care that was set out in the plan was no longer necessary as a result of the resident's change in condition.
The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when, the resident’s care needs changed or when care set out in the plan was no longer necessary.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #003310-18 and CIS #2710-000002-18.

2. The licensee failed to ensure that when a resident was reassessed and the plan of care reviewed and revised, (b) if the plan of care was being revised because care set out in the plan had not been effective, the licensee shall ensure that different approaches were considered in the revision of the plan of care.

Resident #010 had a history of falls from October 2017 to February 2018. The resident's fall risk was assessed as high risk for falls.
The clinical record was reviewed and the universal falls prevention and injury reduction strategies were initiated in the resident's written plan of care in September 2017; however did not include other falls prevention strategies.
The licensee's policy called "Fall Prevention and Injury Reduction Program", index CARE5, and effective October 2016, indicated in their inter-professional program for falls interventions/approaches for residents that were assessed as high risk for falls, that other strategies could be implemented.
The DOC was interviewed and acknowledged that they had not considered these different approaches for falls prevention for resident #010, and there was no documentation in the plan of care that any other falls prevention strategies were attempted after resident #010 had a fall risk assessment in October, November or December 2017.
The licensee failed to ensure that when resident #010 was reassessed and the plan of care reviewed and revised, that when the care set out in the plan had not been effective, the licensee should ensure that different approaches were considered in the revision of the plan of care.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #003310-18 and CIS #2710-000002-18.

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 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 (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. 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; and to ensure that when a resident is reassessed and the plan of care reviewed and revised, that (b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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 applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, (b) was complied with.

In accordance with Ontario Regulation 79/10, s. 48. (1) required every licensee of a long-term care home to ensure that the following interdisciplinary programs were developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee's policy called "Return from Hospitalization", index CARE5-010.02, and effective October 2016, directed staff to complete an Environmental Fall Prevention Scan of the resident's room and belongings before they return from hospitalization and repeated within 24 hours of their return; a Fall Risk Screen completed by a regulated health professional within 24 hours; re-evaluate the universal Fall Prevention and Injury Reduction Strategies; if the resident's Falls Risk Screen indicated a score of 16 or more then a Fall Risk Assessment was to be completed by a regulated health professional within 72 hours to determine the resident specific risk and actions; and an interdisciplinary team huddle to be conducted within 72 hours of the resident's return from hospitalization.
The resident returned from hospital in February 2017. The clinical record was reviewed and there was none of the assessments completed as directed in the licensee's policy and procedures for when a resident returned from hospitalization.
RN #105 was interviewed and told LTCH Inspector #527, that they complete a number of assessments when the resident returned from the hospital, such as the Falls Risk Screen and Assessment, if they were high risk. The RN said they completed the skin and pain assessments, took pictures of any wounds and other assessments that they were not able to recall.
The DOC was interviewed and acknowledged that staff were expected to complete the assessments outlined in the "Return from Hospitalization" policy; however they assumed the resident was palliative care and this was their focus.
The licensee failed to ensure that their "Return from Hospitalization" policy and procedures were complied with as it related to the assessments and care for resident #010.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #00331010-18 and CIS #2710-000002-18.

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 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, (b) is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) 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. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee's 2017 annual program evaluation for the Falls Program and the Skin and Wound Care Program were reviewed by LTC Homes Inspector #527, which identified

that there were no dates in the written record of when the changes were implemented.
The Administrator/DOC was interviewed and they stated that there was a summary of changes; however there were no dates of when those changes were implemented.
The licensee failed to ensure the written record of the 2017 annual program evaluation for the Falls and Skin and Wound Care Programs included the dates of when their changes were implemented.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #003310-18 and CIS #2710-000002-18.

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions were documented.

A) Resident #010 returned to the home from the hospital in February 2018, after receiving treatment for an injury.
The resident's skin assessment identified the resident had new areas of altered skin integrity.
The licensee's policy called "LTC - New Wound", index CARE12-010.02, and last reviewed on July 31, 2016, directed staff that for a new wound the registered staff were to enter the appropriate treatment protocol on the treatment administration record (TAR)
The clinical record was reviewed and there were physician orders for the treatment of the resident's new wounds on both heels.
The DOC was interviewed and acknowledged the physician had ordered the type and frequency of the treatments for the areas of altered skin integrity for resident #010, but staff forgot to transcribe the orders onto the treatment administration record (TAR) and sign off when the treatments were completed. The DOC stated that skin and wound care was performed on the areas of altered skin integrity and there was no negative outcome for the resident; however there was no documentation on the TAR.

B) Resident #010 had an unwitnessed fall resulting in an injury and was transferred to the hospital in February 2018.
The licensee's policy called "Post Fall Management", index CARES-010.05, and effective October 2016, was reviewed and directed staff to complete a post-fall assessment by the nurse immediately following the fall, and if the fall was unwitnessed the head injury routine was initiated, including neurovitals.
The clinical record was reviewed and the post-fall assessment was initiated; however the assessment was incomplete. The nurse did not complete the vital signs, head injury

routine and/or oxygen saturation as required on the post-fall assessment tool. The post-fall assessment tool was documented as not applicable for vital signs. The progress notes were reviewed and RN #105 had documented that they were unable to assess due to the resident refusing to let staff touch them.
RN #105 was interviewed and stated that they were unable to complete the vital signs, head injury routine and other assessments as the resident refused to let any of the staff touch them.
The DOC was interviewed and acknowledged that registered staff were expected to complete the post-fall assessment to include vital signs, neurovitals with the head injury routine, oxygen saturation; however the resident wouldn't let anyone touch them. The DOC acknowledged that they placed a pillow under the resident and their head was resting on PSW #100's knee. The DOC stated that when the staff member had the resident's head on their knee for comfort, they could have checked the resident's pulse, respirations, potentially other vital signs and/or neurovitals; however this was not done.

The licensee failed to ensure that any actions taken with respect to resident #010, under the skin and wound care and falls prevention program, including interventions and the resident's responses to interventions were documented.

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 following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. In addition, to 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iii) was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Resident #010 returned from the hospital in February 2018, after being treated for an injury. The resident had a skin and wound care assessment, which identified the resident had altered skin integrity.
The licensee's policy called "LTC - Skin and Wound Care Program", index CARE12-P10, and last modified in August 2017, indicated that the standard was that an interdisciplinary team approach was used in the assessment and care planning for each resident who demonstrated impaired skin integrity. In addition, the skin and wound care program directed to make referrals as applicable to the Registered Dietitian (RD) using the Nutrition Care Referral Form.
The clinical record was reviewed and there was no referral to the RD when the resident returned from the hospital with altered skin integrity.
RN #105 was interviewed and said that when a resident returned from the hospital they complete a skin assessment and if the resident had altered skin integrity, they were expected to make a referral to the RD.
The DOC was interviewed and acknowledged that staff were expected and should have made a referral to the RD for resident #010, as a result of their altered skin integrity.
The licensee failed to ensure that when resident #010 was exhibiting altered skin integrity, the resident was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

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, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee failed to ensure the written record of the annual Infection Prevention and Control program evaluation (d) included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The 2017 Annual Program Evaluation for the Infection Prevention and Control program was reviewed by LTC Homes Inspector #527. The evaluation did not include the date that the changes were implemented based on the summary of changes identified in the annual program evaluation.
The DOC was interviewed and acknowledged that the annual program evaluation report for Infection Prevention and Control included the summary of the changes; however there were no dates that those changes were implemented.

2. The licensee failed to ensure that on every shift, (a) symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

The licensee's policy called "Infection Surveillance Protocols", index IPC6-010.01, and last revised December 2016, was reviewed and the policy directed registered staff to complete the “Resident Home Area (RHA) Daily Infection Control Surveillance Form”

using the Best Practices for Surveillance of Health Care-associated Infections (Provincial Infectious Diseases Advisory Committee – PIDAC, July 2014). The registered staff were expected to review the RHA Surveillance Form daily and update on each shift.
The home's surveillance forms were reviewed by the LTCH Inspector #527 and identified they had three different surveillance forms that registered staff were expected to complete. When the LTCH Inspector reviewed the Public Health line list, the documented resident cases revealed that during the Acute Respiratory Illness (ARI) Outbreak from February to March 2018, the line list was not initiated when the onset of resident cases of ARI began. The residents displaying symptoms were increasing and by a specific date in February 2018, the home contacted Public Health and at this time the home reported ten resident cases of ARI. Public Health declared an ARI Outbreak facility-wide.
RPN #140 was interviewed and acknowledged that they were expected to track infections on their units, but was not aware that they were to review the RHA Surveillance form on each shift and daily to monitor for potential clusters and/or trends.
The DOC and ADOC, who were the Infection Prevention and Control (IPAC) Leads were interviewed and stated that registered staff were expected to review and document on the RHA Daily Infection Control Surveillance form every shift and when residents exhibit any signs or symptoms of an infection that meet the Public Health approved case definition of an infection, the registered staff were to complete the Public Health line list.
The DOC acknowledged that registered staff were delayed in tracking and reporting the initial ARI resident cases on the Public Health line list for several days, which resulted in recommendations from Public Health and a delay in initiating infection prevention and control measures.
The licensee failed to ensure that on every shift, registered staff were documenting and monitoring symptoms indicating the presence of infection in residents, in accordance with evidence-based practices.

This area of non-compliance was identified during a Critical Incident System (CIS) Inspection, log #004128-18 and CIS #2710-000003-18.

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, (e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. In addition, to ensure that on every shift, (a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

Issued on this 26th day of June, 2018

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

Original report signed by the inspector.