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
Oct 18, 2017	2017_610633_0019	022812-17	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

STIRLING HEIGHTS
200 STIRLING MacGREGOR DRIVE CAMBRIDGE ON N1S 5B7

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

SHERRI COOK (633), AMIE GIBBS-WARD (630)

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): October 2-6, 2017.

The following inspections were conducted concurrently during this inspection:

Complaint IL-526677-LO/Log #021015-17 related to fall prevention.
Critical Incident System 2863-000013-16/ Log #026990-16 related to a resident fall.
Critical Incident System 2863-000015-16/ Log #031858-16 related to alleged improper care.
Critical Incident System 2863-000018-16/ Log #034403-16 related to a resident fall.
Critical Incident System 2863-000005-17/ Log #007615-17 related to a resident fall.
Critical Incident System 2863-000010-17/ Log #014516-17 related to a resident fall.
Critical Incident System 2863-000011-17/ Log #015258-17 related to a resident fall.
Critical Incident System 2863-000014-17/ Log #017343-17 related to a resident fall.
Critical Incident System 2863-000016-17/ Log #020982-17 related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Resident Assessment Instrument Coordinator, Registered Nurses, a Registered Dietician, Registered Practical Nurses, Nurse's Aides, Personal Support Workers, a Residents' Council member, a Family Council member, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Additionally, the inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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. (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 plan of care was revised at any time when the resident’s care needs changed.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC). This report stated that a resident had fallen which resulted in an injury. This report also stated that the resident had been independent with a specific activity of daily living up until a previous fall. At this time, the resident sustained an injury and had required another specific intervention.

At multiple times during a specific day, the resident was observed with a specific device.

A Personal Support Worker (PSW) stated that the resident had a history of falls with injuries and specific interventions were in place. They also said that the resident was no longer able to perform a specific activity of daily living independently.

A Registered Practical Nurse (RPN) said that the resident had a history of falls that had resulted in injuries. The RPN said that after the falls the resident's condition declined and another specific intervention was put in place. The RPN also said that the resident used a device and the resident was unable to use this device on their own. The RPN also said that the physician wrote an order for the device and that this was listed in the electronic Medication Administration Record (eMAR) for the registered staff to check on each shift. The RPN reviewed the plan of care in Point Click Care (PCC) and acknowledged that the device was not included.

The clinical record for the resident in PCC included documentation related to the resident's fall history and use of devices. There was also a physician order on a specific date for a specific device and a physiotherapy assessment that indicated that the resident used a specific device.

The plan of care for the resident did not provide direction for staff regarding their devices and interventions.

The Director of Care (DOC) said that they were aware that the resident's condition declined after the fall and that they were using a specific device. The DOC said that at the request of the family, the resident was using another device. The plan of care for the resident was reviewed with the DOC and they acknowledged that at the time of the

inspection it had not been revised to reflect the changes in the resident's condition and related interventions. The DOC also said that it was the expectation in the home that the plan of care would be revised at any time when the resident's care needs changed.

The licensee has failed to ensure that the plan of care for a resident was revised when the resident's care needs changed.

The severity of the issue was minimal harm/potential for harm and the scope of the issue was isolated. The home had a history of related and multiple unrelated non-compliance. [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 plan of care is revised at any time 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. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when they experience the following weight changes: a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more,

over six months.

During a Stage 1 of the Resident Quality Inspection (RQI), a Registered Practical Nurse (RPN) reported that a resident had a low Body Mass Index (BMI) but was not on nutritional interventions to support weight gain.

Review of the "Weight and Vitals" section of the clinical record for the resident showed that they had experienced a weight loss over a specific period of time and there was no documented assessment regarding this weight loss.

A Personal Support Worker stated that they were unsure if the resident had experienced any changes in their weight. The PSW said that the resident's food intake was variable.

A RPN reviewed the clinical record for the resident and stated that the resident had experienced a weight loss, was not on any nutritional supplements and a referral was not completed regarding their decreased intake or weight loss. The RPN said that when a resident's weight has changed they no longer completed referrals in Point Click Care (PCC), instead the Registered Dietitian (RD) would check in PCC for weight changes and then follow-up.

The RD stated that if a resident experienced a significant change in weight it was expected that the registered staff would send a referral to the RD electronically in PCC and the RD would also check the weight notifications in PCC. The RD said that they had assessed the resident in the past. The RD also said that at the time of the inspection the resident was being followed by the Nutrition Manager (NM). The RD acknowledged that the resident's weight loss had not been identified or addressed in a recent assessment. The RD also acknowledged that the weight record for the resident showed a weight loss and they had not received a referral from the nursing staff or NM regarding this change. The RD agreed that they had not assessed the resident based on a review of their weight variances in PCC.

The home's policy titled "Weight and Height Monitoring" with reviewed date "July 31, 2016" included the following procedures:
- "The RD/NM/Designate reviews the weight report monthly to ensure all significant weight changes and undesirable insignificant weight changes have been addressed".
- "Weight Variances: the RD re-assesses the resident's nutritional requirements and current intake, as well as other possible reasons for weight variances".

The Administrator and DOC said it was the expectation in the home that the "Weight and Height Monitoring" policy would be followed. They also said that it was the expectation that weight changes would be assessed using an interdisciplinary approach.

The licensee has failed to ensure that a resident was assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when they experience the following weight changes: a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more, over six months.

The severity of the issue was minimal harm/potential for harm and the scope of the issue was isolated. The home had a history multiple unrelated non-compliance. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 a resident is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated when they experience the following weight changes: a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more, over six months, to be implemented voluntarily.

WN #3: 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. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure to ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and
(c) a written record is kept of everything provided for in clauses (a) and (b).

The policy titled "Medication", effective August 31, 2016, stated that "medication incidents will be summarized, discussed and action plans developed as necessary" and that the "Medication Incident Reporting Algorithm (MIRA)" can be referenced for additional clarification on the incident reporting process". Review of the MIRA stated that medication incident reports would be "analyzed by the Interdisciplinary Care Team for on-going trending".

The Director of Care (DOC) stated that the review of medication incidents and adverse drug reactions occurred during the multidisciplinary Medical Advisory Committee (MAC) meetings. The most recent MAC minutes stated that "medication incidents on hold as data input has been a challenge at the home. Will defer discussion and report to next MAC meeting with the goal of having more accurate data".

The DOC stated that a quarterly analysis of all medication incidents in the home was not completed in the year 2017. The DOC agreed that the previous MAC meeting minutes only documented the medication incidents by type and did not include what changes

were made if any and when these changes were implemented. The DOC further agreed that there was not a process in place to analyze medication incidents and adverse drug reactions that had occurred in the home. The DOC explained that they were aware that all medication incidents needed to be analyzed for trending and they said that the home's policy did not include a process related to the analysis of all medication incidents that occurred in the home.

The inspector was provided a draft of the revised "Medication" policy effective August 31, 2016, that now stated that "medication incidents would be analyzed quarterly and would include review of the drug utilization trends, medication incidents and adverse drug reactions, changes would be identified to improve the system and a written record would be kept of the quarterly evaluations and any changes implemented".

The licensee has failed to ensure to ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and
(c) a written record is kept of everything provided for in clauses (a) and (b).

The severity of the issue was potential for harm/risk and the scope of the issue was widespread. The home had a history multiple unrelated non-compliance. [s. 135. (3)]

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,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review are implemented; and
(c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that that every use of a physical device to restrain a resident under section 31 of the Act was documented and that the following was documented: the circumstances precipitating the application of the physical device; what alternatives were considered and why those alternatives were inappropriate; consent; as well as assessment, reassessment and monitoring, including the resident's response.

At multiple times during the day, a resident was observed with a device.

A Personal Support Worker (PSW) stated that the resident had a history of falls and used this device.

A Registered Practical Nurse (RPN) said that the resident had a history of falls and used

a device. The RPN said that the physician wrote an order for the device and it was listed in the electronic Medication Administration Record (eMAR) for the registered staff to check on each shift. The RPN reviewed the plan of care in Point Click Care (PCC) for the resident and acknowledged that the device was not included. The RPN also said they thought that the family had consented to the use of the device but could not locate the signed consent in the resident's chart.

The electronic and hard copy clinical record for the resident was reviewed and was found not to include a "Least Restraint Assessment Form". There was no observed other type of documented assessment related to the circumstances precipitating the application of the device, what alternatives were considered or the resident's response to the device.There was also no observed consent from the Substitute Decision Maker (SDM) within the clinical record.

The Director of Care (DOC) said that at the request of the family the resident was using a device. The DOC said that there had been an order for the device at the time from the physician. The DOC also said that it was the expectation in the home that there would be documentation in the resident chart regarding SDM request and consent and there was not. The DOC said that they followed up with nursing staff and the Physio Therapist and documentation was being done to correct the items that were missed.

The Administrator and DOC stated that they had reviewed the documentation regarding the device and they acknowledged that it did not meet their expectation regarding documentation of an assessment, SDM consent or the physician order. They said that it was the expectation that the legislation was met.

The licensee has failed to ensure that that the use of a physical device under section 31 of the Act was documented and that the following was documented: the circumstances precipitating the application of the physical device; what alternatives were considered and why those alternatives were inappropriate; consent; as well as assessment, reassessment and monitoring, including the resident's response.

The severity of the issue was minimal harm and the scope of the issue was isolated. The home had a history multiple unrelated non-compliance. [s. 110. (7)]

Issued on this 19th day of October, 2017

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

Original report signed by the inspector.