Original Public Report

Report Issue Date: October 29, 2024
Inspection Number: 2024-1236-0004
Inspection Type: Complaint Critical Incident
Licensee: Revera Long Term Care Inc.
Long Term Care Home and City: Telfer Place, Paris

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 22, 23, 2024

The following intake(s) were inspected:

- Intake: #00124369, related to a resident's fall.
- Intake: #00127897, complaint related to pain management.

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

Infection Prevention and Control
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (a)

Plan of care
s. 6 (4) The licensee shall 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.

The licensee has failed to ensure that the staff involved in the of care of the resident collaborated with each other in the specific assessment of the resident so that their assessments were consistent with and complemented each other.

Rational and summary
A clinical record review for the resident showed multiple resident assessments completed for admission, those assessments included information that showed assessments were not consistent with and complemented each other.

In interviews the Director of Care (DOC) and Assistant Director of Care (ADOC) said those assessments were not consistent with and complementing each other, there was a possibility that the resident's assessment outcome would have been different if the accurate information was selected in the assessment. They said the staff should collaborate with each other to ensure their assessments were consistent with and complemented each other.

There was a risk to the resident when the assessments completed by different staff members were not consistent with and complemented each other.

Sources: resident's record reviews, interviews with DOC and ADOC.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
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.

The licensee has failed to ensure the provision of the care set out in the plan of care was documented for a resident.

Rational and Summary
A clinical record review for a resident showed specific care plan interventions and direction in the Kardex to implement those interventions.

A review of the Documentation Survey report showed no documented record of the specific interventions or tasks.

In interviews a Registered Nurse (RN) and a Personal Support Worker (PSW) said they applied the specific interventions.

In interviews the DOC and ADOC confirmed there was no documented record related to the provisions of care.

There was risk to the resident when the provisions of care set out in the plan of care were not documented.

Sources: resident's record reviews, interviews with RN, PSW, DOC and ADOC.

WRITTEN NOTIFICATION: Falls Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (3)

Falls prevention and management
s. 54 (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home.

The licensee has failed to ensure that the equipment and devices that provided for strategies to reduce or mitigate falls were readily available in the home.

Rational and Summary:
Clinical record review for a resident showed assessments and progress notes specifying a certain equipment to be applied to the resident, the equipment was not readily available and had to be ordered.

In Interviews the DOC and ADOC confirmed the specific equipment was used as a fall's prevention and injury prevention strategy. They said the resident required the specific equipment at the time of admission, but the home did not have the equipment readily available. The DOC and ADOC said the equipment was ordered and now the home has the equipment in stock and readily available.

There was a risk to the resident as the equipment was not readily available in the home.

Sources: resident's record reviews, interviews with DOC and ADOC.

WRITTEN NOTIFICATION: Pain Management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 57 (2)
Pain management
s. 57 (2) Every licensee of a long-term care home shall ensure that when a resident's

pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Rational and Summary:
A clinical record review for a resident on a certain dates showed the resident was in pain, they received their pain medication and it was ineffective. The record review showed the pain assessment was not completed on those dates.

In an interview ADOC and DOC confirmed pain assessment was not completed when the resident's pain did not improve with the initial interventions and the resident continued to complain of pain. The resident had a change in the pain medications and pain management interventions. The ADOC said the expectation was for the Pain Assessment-V2 to be completed quarterly and at times when the pain was not relieved by initial interventions.

There was a risk to the resident when their pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Sources: record review for the resident and staff interviews with DOC and ADOC.

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (5) 3. v.
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under

subsection (1), (3) or (4) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
v. the outcome or current status of the individual or individuals who were involved in the incident.

The licensee has failed to include the outcome or the status of a resident who was involved in the critical incident submitted to the Director.

Rational and summary:
The home submitted a Critical Incident System (CIS) report related to an incident involving a resident. The incident caused and injury that resulted in transfer to hospital and change in condition.

The home did not update the CIS with the outcome of the hospitalization and the current status of the resident.

In an interview the DOC said they had submitted the CIS, but they forgot to complete the required updates.

There was minimal risk to the resident.

Sources: review of the CIS, interview with DOC.