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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 1, 2013	2013_188168_0008	H-002170-12	Critical Incident System

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

TELFER PLACE
245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8

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

LISA VINK (168)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 24 and 29, 2013

This inspection is related to a Critical Incident Report that was submitted by the home as well as other issues related to the care and services provided to residents as identified by the home during their internal investigation into the incident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Practical Nurse (RPN), Registered Nurse, personal support workers (PSW), recreation staff and residents.

During the course of the inspection, the inspector(s) observed the care and services provided to residents, reviewed clinical records of identified residents, reviewed relevant staff education records and internal investigation notes.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Critical Incident Response

Dignity, Choice and Privacy

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 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:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has not ensured that each resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

1. In 2012, resident #001 was involved in an incident, which had the potential to cause injury, at the noon meal.

Staff present in the area, at the time of the incident, quickly responded to "clean up" the resident and reported the incident to other care providers.

Interview with evening staff confirmed that the resident was not assessed until preparing the resident for bed after dinner.

The registered staff who assessed the resident at bedtime identified an injury and applied a treatment.

The staff were unaware of the cause of the injury at the time it was identified.

The following day the RPN (who was assigned care of resident #01 the day before) completed a late entry in the progress notes which indicated that the resident was assessed following the incident.

Interview conducted with the RPN on January 29, 2013, confirmed that the information in the late entry progress note, was not accurate and that no assessment was completed during the day shift.

Despite interventions in the resident's plan of care to toilet after meals she was not toileted following lunch on the specified day.

Resident #01 was not cared for in a manner consistent with her needs on a specified day in 2012.

2. Resident #02 was not cared for in a manner consistent with her needs, for a period of time, while staff were toileting/providing care to the resident in the evening hours.

According to an interview with a PSW and statements from a separate PSW, following a diagnosed injury, the resident experienced what they believed to be pain during the provision of evening care as evidenced by a marked change in the resident's

behaviour.

The resident was historically known to be resistant to care however since the injury there was an increase in frequency and intensity of behaviours specifically crying, call out, and physical resistance to evening care, including transfers, toileting, changing clothing and washing, for a period of time, up to a few weeks.

The two PSW staff did not modify the residents evening routine, for an extended period of time, despite their identification of ongoing distress to the resident.

Once the residents routine was modified, (fewer transfers and care administered while in bed), staff noted a decrease in the behaviours demonstrated.

The plan of care for resident #02 directs staff to report signs of pain during dressing.

Resident #02 was not cared for in a manner consistent with her needs. [s. 3. (1) 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 each resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #2: 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 resident is not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the residents care needs change or care set out in the plan is no longer necessary.

1. The plan of care for resident #01 identifies that the resident will ask to go to the bathroom, is to be toileted with morning care, following meals and on request.

Interview with three PSW's identified that the resident no longer uses the toilet (unless following a suppository) and uses an incontinent product for containment, which is changed routinely.

On January 29, 2013, the resident was observed to be changed following the noon meal and at no time during the observation period did she request to go to the bathroom.

Interview with the ED and DOC confirm that the resident has had a change in status and that the plan of care related to toileting is no longer reflective of actual care needs. [s. 6. (10) (b)]

2. 2. The plan of care for resident #04 identifies that the resident is to be toileted before and after meals and at bedtime.

Interview with three PSW's identified that the resident is consistently incontinent of bladder and bowel and is usually only toileted for a bowel movement. The resident uses an incontinent product for containment, which is changed routinely.

On January 29, 2013, the resident was observed to be changed following the noon meal and demonstrated no signs of wetness or odours during the observation period.

Interview with the ED and DOC confirm that the resident has had a change in status and that the plan of care related to toileting is no longer reflective of actual care needs. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. A person who had reasonable grounds to suspect that any of the following had occurred or might occur did not immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

In 2012, resident #01 was involved in an incident at the noon hour.

The resident was not assessed, no first aid or treatment was administered until the resident was being prepared for bed following the evening meal.

When the resident was assessed at bedtime the resident was noted to have an injury.

The RPN completed a late entry in the resident's progress notes the following day, indicating that the resident was assessed following the incident.

The RPN later admitted, during an interview, that the resident was not assessed following the incident, during the day shift, and that the documentation was inaccurate.

The management of the home became aware of the incident 4 days later, however did not make the report to the Director until 11 days after awareness of the incident.

Issued on this 1st day of February, 2013

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

L Vink