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
Sep 14, 2018	2018_687607_0004	023316-17	Complaint

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

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 22, 23, 28 and March 1 and 2, 2018

Two other complaint inspections (Inspection #'s 2018_687607_0005, 2018_687607_0006), (Log #s 022504-17, 024475-17) were completed concurrently during this Complaint inspection related to resident care areas.

In addition, the following log was inspected during this Complaint inspection : Log # 023316-17.

Summary of Intake Log:

1) Log #023316-17: A Complaint regarding notification of family members related to Medication management and risk for elopement.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC) Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and family members.

During the course of inspection, the Inspector reviewed clinical health records, observed staff to residents interactions, reviewed complaint records and applicable policies.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the Substitute Decision Maker (SDM), if any, and the designate of the resident/SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint Log #023316-17 on an identified date, related to notification of family members and medications.

During an interview on an identified date and time, resident #001 who is capable of making decisions related to care, indicated not being notified when there was a change in the resident's medications.

A review of the resident's plan of care on an identified date and verification with the resident, indicated there was documented evidence of the resident signing for consent to treatment upon admission.

During an interview on an identified date, Registered Practical Nurse (RPN) #125 indicated that when there was a medication change, the expectation was the resident be notified, if the resident was capable, as well as the family member. The RPN verified that there was no documented evidence in resident #001's physician orders to indicate that the resident or the family members were notified related to medication changes, but indicated that this could have been documented in the progress notes.

Further review of the physician orders and progress notes for resident #001, for a 12

month period, identified that on one occassion the resident or the resident's family member was notified of medication change, there was no other documented evidence to indicate that the resident or the family members were notified at any other time when there was a medication change.

During a telephone interview on an identified date and time, RPN #138 who had process some of resident #001's physician orders, related to medication changes indicated that whenever there was a medication change, the RPN would always notify the resident or resident's family member and document the notification and the changes in the resident's progress notes.

During an interview on an identified date, the Director of Care (DOC) indicated that the licensee's expectation is that whenever there was a medication change, the resident and or family member should be notified.

The licensee failed to ensure that when there a was change in resident #001's medications, the registered staff failed to ensure that the resident was given an opportunity to participate in the development and implementation of the plan of care, by not notifying the resident or the resident's family members of the changes. [s. 6. (5)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint Log #023316-17 on an identified date, related to notification of the SDM related to medications.

During an interview on an identified date and time, resident #001’s family member indicated that no notification was provided to the family member, as requested, related to changes in medications and changes to care. The family member indicated even with request to be notified of changes to resident #001’s care, the Long-term care home continued to deny them of these request, as the Long-term care home indicated that resident #001 was capable of making own decisions around care.

During an interview on an identified date, resident #001 who is capable of making decisions related to care, indicated the desire to have one of the family member be notified of changes related to the resident’s care. The resident further indicated that the home had not asked if the resident would have liked the family members to be notified of

any changes to the resident's care.

A review of the resident's plan of care on an identified date, did not indicate that the family members request were documented in the plan of care.

During an interview on an identified date and time, Registered Practical Nurse (RPN) #125 indicated that when there was a medication change or change in care, the expectation is the resident was to be notified, if the resident was capable, as well as, the family member.

During an interview on an identified date and time, the DOC indicated not asking resident #001, if the resident would like the family members to be notified of any changes related to the resident's care.

The licensee failed to ensure that the provision of the care set out in the plan of care was documented. When resident #001 family members requested to be notified of changes to the residents care, the DOC did not ask resident #001 for consent to this request and ensure this request was documented in the resident's written plan of care. [s. 6. (9) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment the resident cultural, spiritual and religious preferences and age-related needs and preferences.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint Log #023316-17 on an identified date, related to notification of the family members.

During an interview with resident #001 on an identified date, the resident indicated to the Inspector they enjoyed praying and that their religious preference was an identified religion and they often prayed first thing in the mornings.

A review of resident #001's written plan of care on an identified date and time, had no evidence to indicate there were interventions in place related to the resident identified religious preference.

During an interview on an identified date and time, PSW #102 and RPN #101 both were able to identify resident #001's religious preference. Registered Practical Nurse #101 further indicated that there was no documented evidence in the written plan of care to indicate resident #001's religious preference.

During an interview on an identified date and time, the DOC indicated that there was no documented intervention in the written plan of care to identify resident #001's religious preference and further indicated the licensee expectations is that residents' religious preference be included in the written plan of care.

The licensee failed to ensure that resident #001's written plan of care was based on, at a minimum, interdisciplinary assessment of the resident cultural, spiritual and religious preferences, specifically to indicate the resident's religious preferences. [s. 26. (3) 22.]

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Issued on this 19th day of September, 2018

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

Original report signed by the inspector.