Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: June 28, 2024

Inspection Number: 2024-1083-0003

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Thorntonview, Oshawa

Lead Inspector	**Inspector Digital Signature**
Rexel Cacayurin (741749)	Rexel J Cacayurin Digitally signed by Rexel J Cacayurin Date: 2024.07.10 17:40:16 -04'00'

Additional Inspector(s)
Edith Sam (741787)
Najat Mahmoud (741773)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 29-31, 2024 and June 3-6, 2024.

The following intake(s) were inspected:

- Intake: #00099141 – related to an allegation of staff to resident abuse.
- Intake: #00106067 – a complaint related to door of the home.
- Intake: #00109623 – first follow-up to Compliance Order (CO) #001 - FLTCA, 2021 - s. 24 (1) Duty to protect, Compliance Due Date (CDD) of April 1, 2024.

- Intake: #00112687 – related to fall.
- Intake: #00114503 – related to an allegation of resident-to-resident abuse.
- Intake: #00116738 – a complaint related to missing items.

The following intake was completed in this inspection:

- Intake: #00103241 - related to fall.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1083-0001 related to FLTCA, 2021, s. 24 (1) inspected by Najat Mahmoud (741773)

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Compliance with manufacturers' instructions

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 26

Compliance with manufacturers' instructions

s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The licensee failed to ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

Rationale and Summary

A disinfectant wall unit was observed in the housekeeping closet which was being used by the home to dilute and dispense the general disinfectant for cleaning and disinfection of contact surfaces in the home.

The housekeeper indicated that they had not been testing the diluted disinfectant solution from the wall unit since the transition to paperless documentation.

The Environmental Services Manager (ESM) confirmed that housekeeping staff were expected to document in their verification log and test the concentration of the

diluted solution using pH strips provided by Ecolab. This was to be done at the start of their shifts and following the dispensing of solutions from the wall unit to refill their open containers. Furthermore, they verified that there were no records of the verification log due to staff not testing the disinfectant solution concentration.

An email was received by the ESM from the manufacturer's representative, they indicated that to ensure proper dilution with each spray bottle or container fill, the disinfectant test strip should be utilized. Additionally, it was emphasized that any open container containing the diluted cleaner and disinfectant should be replaced at a minimum daily.

By failing to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions, the licensee increased the risk for health care-associated infections.

Sources: Observation, interviews with housekeeper and ESM, manufacturer's email, and Verification disinfectant concentration log.[741749]

WRITTEN NOTIFICATION: Mobility devices

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 43
Mobility devices
s. 43. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis.

The licensee has failed to ensure that resident, had a specialized device upon return from the hospital.

Rationale and Summary

The resident returned from the hospital on a specified date, post operatively.

The physiotherapist acknowledged a change in the mobility status of the resident, thus needing a specialized device. Further, they indicated that the specialized device was made available on a specified date.

The Personal Support Worker (PSW) and Registered Practical Nurse (RPN) confirmed in separate interviews that the resident was left in bed for several weeks because they did not have the specialized device.

The resident's progress note indicated the specialized device was received on a specified date.

A record review of the resident's skin and wound chart showed the skin alteration progressively deteriorating.

Failure to ensure that resident had a mobility device had negatively impacted their wound healing and compromised their mobility status.

Sources: CIR, interviews with PSW, RPN, physiotherapist, skin and wound record review. [741787]

WRITTEN NOTIFICATION: Dress

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 44

Dress

s. 44. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with the resident's preferences, in their own clean clothing and in appropriate clean footwear.

The licensee failed to ensure that a resident was dressed appropriately in clean clothing.

Rationale and Summary:

During multiple observations, it was identified that a resident wore a hospital gown and had no pants on while in the resident common areas. Two PSWs indicated that the resident did not have pants on due to frequent incontinent episodes and the need for laundering. The two PSWs, and the Assistant Director of Care (ADOC) indicated that the resident wearing a hospital gown with no pants on was not dignifying.

Failure to dress the resident appropriately in their own clean clothing did not promote dignity.

Sources: Observations, resident's clinical records, Interviews with staff and the ADOC. [741773]

WRITTEN NOTIFICATION: Skin and wound care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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,

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument specifically design for skin and wound upon return from the hospital.

Rationale and Summary

The resident sustained a fracture after an unwitnessed fall for which they received surgical intervention. The resident's electronic health care record indicated that the resident did not receive a total body, skin and wound assessments upon return from the hospital.

The RPN, who was the skin and wound care lead, indicated the expectation in the home was for residents to receive a head-to-toe skin assessment, using the total body skin and wound tool, when there was skin alterations, including pressure injuries and surgical incision.

By not ensuring the resident received a skin assessment by a member of the registered nursing staff upon their return from the hospital, the resident was at risk of having areas of altered skin integrity going unnoticed and or untreated.

Sources: CIR, resident's progress notes, assessment documentation, and interview with RPN. [741787]

WRITTEN NOTIFICATION: Skin and wound care

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (d)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated; and

The licensee has failed to ensure that resident #004, who was dependent on staff for repositioning, was repositioned every two hours or more frequently.

Rationale and Summary

The resident returned from the hospital post-operatively.

The readmission physiotherapy assessments indicated resident required specified care for their mobility and, were unable to reposition themselves. Furthermore, the Point of Care (POC) daily task report indicated that the resident was not repositioned every two hours from specified dates.

The RPN confirmed the expectation for PSW staff was to reposition the resident every two hours while in bed. PSW indicated the resident should have been repositioned every two hours.

Failure of the home to ensure the resident was repositioned every two hours did not promote wound healing and led to skin alteration deterioration.

Sources: CIR, interviews with RPN, PSW, and Physiotherapist, resident's POC daily task report, and physiotherapy assessments. [741787]

WRITTEN NOTIFICATION: Skin and wound care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (e)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(e) a resident exhibiting a skin condition that is likely to require or respond to nutrition intervention, such as pressure injuries, foot ulcers, surgical wounds, burns or a worsening skin condition, is assessed by a registered dietitian who is a member of the staff of the home, and that any changes the registered dietitian recommends to the resident's plan of care relating to nutrition and hydration are implemented. O. Reg. 246/22, s. 55 (2); O. Reg. 66/23, s. 12.

The Licensee has failed to ensure that the resident who had skin alteration was assessed by a registered dietitian upon return from the hospital.

Rationale and Summary

The resident returned from the hospital on a specified date, with skin alterations.

The progress note indicated a dietitian referral was requested for a skin alteration. There was no dietitian assessment completed until a specified date. The Registered Dietitian confirmed a referral was not received upon the resident's readmission to the home.

By not ensuring the resident received an assessment by the dietitian delayed interventions to prevent skin alterations and promote healing.

Sources: CIR, interview with dietitian, resident's progress note. [741787]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (a)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The licensee failed to ensure that a resident who was incontinent, received an assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Rationale and Summary:

A complaint was submitted to the Director regarding a resident's missing clothing.

During multiple observations it was identified that the resident wore a hospital gown and had no pants on. Two PSWs indicated that the resident did not have pants on due to frequent incontinent episodes and laundering. One PSW indicated that the resident used a specialized pad while the other PSW indicated that the resident required other specialized incontinent products. The care plan did not indicate which incontinent product to use.

Clinical records indicated that there was no continence assessment using an appropriate assessment instrument that would have assisted the staff in creating an individualized plan to promote continence for the resident. The ADOC acknowledged that there was no continence assessment for the resident, and thus no individualized plan for the resident. The ADOC indicated that the resident should have had a continence assessment completed.

Failure to use a clinically appropriate assessment instrument specifically designed to assess incontinence resulted in no individualized plan. As a result, resident had frequent incontinent episodes, and was dressed inappropriately, impacting their dignity.

Sources: Observations, resident's clinical records, interviews with PSWs, and ADOC. [741773]

WRITTEN NOTIFICATION: Pain management

NC #008 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 failed to ensure that resident's pain was assessed using a clinically appropriate assessment instrument when their pain was not relieved by initial interventions.

Rationale and Summary

A Critical Incident Report (CIR) was submitted to the Director after a resident hit another resident accidentally with their assistive device. The resident's clinical records were reviewed and indicated that they had a history of pain prior to the incident. The Medication Administration Record (MAR) indicated that the resident had routine and as needed pain medication.

After the incident, the resident experienced worsening pain and had pain medication administered. Progress notes indicated that resident's pain was not relieved by the analgesic and a referral was made to physiotherapy for non pharmacological interventions. The physiotherapist confirmed that they received the referral for the resident's worsened pain. Progress notes also indicated that an order was obtained for another type of pain medication. The interventions continued to be ineffective, and diagnostic imaging was then ordered. There was no

documentation of a clinically appropriate assessment instrument to assess the resident' 's pain on Point Click Care (PCC) when the initial pain was not relieved. Registered Nurse (RN) and the Director of Care (DOC) indicated that a pain assessment on PCC should have been completed.

Failure to assess the resident's pain using a clinically appropriate tool did not promote comfort.

Sources: CIR, resident's clinical records, interview with RN, Physiotherapist, and the DOC. [741773]