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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 28, 2015	2015_263524_0025	018503-15	Resident Quality Inspection

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

TRILLIUM COURT
550 PHILIP PLACE KINCARDINE ON N2Z 3A6

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

INA REYNOLDS (524), CHRISTINE MCCARTHY (588), NANCY JOHNSON (538)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 10, 11, 12, 13, 14, 17, 2015.

The following Critical Incident inspection was conducted concurrently during this inspection:
Log # 018268-15 / CI 2773-000014-15 related to a resident care issue.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Resident Assessment Instrument (RAI) Coordinator, the Nutrition Manager, the Environmental Services Manager, the Recreation Manager, three Registered Nurses, two Registered Practical Nurses, five Personal Support Workers, one Dietary Aide, one Laundry Aide, forty Residents, three Family Members and one Volunteer.

The inspector(s) also conducted a tour of the home, observed care and activities provided to residents, meal service, medication administration, medication storage area, resident/staff interactions, infection prevention and control practices and, reviewed clinical records and plans of care for identified residents, postings of required information, investigation notes and minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **3 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

Observation of an identified Resident's bed system on August 14, 2015, revealed two quarter rails in the up position.

Review of the most recent care plan on August 14, 2015, revealed under the toileting section to "Keep bed rail closest to washroom down and light on at night" and under the Personal Assistive Services Device (PSAD) section to keep "Bed rails in position on both sides to facilitate bed mobility."

Staff interview on August 14, 2015, with a Registered Staff and the Resident Assessment Instrument (RAI) Coordinator confirmed that the care plan for the Resident was inconsistent and provided unclear direction for the use of bed rails.

Staff interview on August 14, 2015, with the Administrator confirmed that it was the home's expectation that the plan of care sets out clear direction to staff who provided direct care to the resident. [s. 6. (1) (c)]

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

Record review of the most recent quarterly review Minimum Data Set (MDS) assessment indicated that an identified Resident was awake most or all of the time in the morning, afternoon and evening and enjoyed a variety of activity preferences.

However, review of the most recent plan of care for the Resident identified under the sleep pattern focus that the resident slept most of the day and night and interventions related to activities included one to one visits during times when the resident was awake and more responsive.

The Recreation Manager confirmed that the MDS activity assessment was not completed in collaboration with all staff involved and the activity assessment of the resident was not consistent with the care plan and did not include the resident's activity preferences based on the assessment. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Record review of the current plan of care revealed under the responsive behaviours interventions that an identified Resident was followed by the in-house behavioural consult support team.

Staff interview on August 13, 2015, with a Registered Nurse (RN)/Behavioural Service Ontario (BSO) lead for the home confirmed that the home’s internal BSO team had not followed the Resident for responsive behaviours. The RN shared that the Resident's

responsive behaviours were currently managed by the interventions in place. The RN confirmed that the care plan was not reviewed and revised when the care set out in the plan was no longer necessary.

Interview on August 13, 2015, with the Director of Care (DOC) confirmed that the care plan had not been revised when the resident's care needs changed and the care in the plan was no longer necessary. [s. 6. (10) (b)]

4. An identified Resident returned from hospital and required a specific care intervention. Record review of the most recent plan of care for the Resident indicated the resident required the specific care intervention due to post-hospital rehabilitation. However, interview with a Registered Practical Nurse on August 14, 2015, revealed the Resident no longer required the use of the specific care intervention and that it was discontinued.

The Resident Assessment Instrument (RAI) Coordinator confirmed that the plan of care had not been reviewed and revised when the residents care needs changed and the care set out in the plan was no longer necessary. The RAI Coordinator confirmed that it was the home's expectation that residents are reassessed and the plan of care reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

5. Record review of the most recent quarterly review Minimum Data Set (MDS) assessment for an identified Resident under the eating section revealed the resident required extensive assistance with one person to physically assist. However, review of the most recent plan of care for this resident only directed staff to provide the following interventions related to eating: "requires verbal cuing to continue eating/pick up food/utensils" with a goal of "maintaining the current level of self-performance (Set up)" for eating.

Interview with the Registered Practical Nurse and Director of Care on August 13, 2015, confirmed the resident's eating needs had changed and the resident required extensive assistance with eating. The Director of Care confirmed that it was the home's expectation that the plan of care was reviewed and revised when the resident's care needs changed. [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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and consistent with and complemented each other; and, that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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:
3. Communication abilities, including hearing and language. 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 an interdisciplinary assessment of the resident's communication abilities, including hearing and language.

Record review of PointClickCare revealed an absence of documentation related to an identified Resident's communication abilites.

Interview with a Personal Support Worker on August 13, 2015, revealed that the staff felt that the resident had difficulty with modes of expressions.

Interview with a Registered staff on August 13, 2015, confirmed that the resident had some difficulty with understanding other resident's verbal expressions.

Interview with the Director of Care on August 17, 2015, after reviewing PointClickCare, revealed an absence of documentation in the care plan related to the resident's communication abilities. [s. 26. (3) 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 the plan of care is based on an interdisciplinary assessment of the resident's communication abilities, including hearing and language, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (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; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included 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 was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Record review revealed the Minimum Data Set (MDS) Section H Continence Quarterly assessment which indicated bowel continence classified as "usually continent".

Record review revealed the Minimum Data Set (MDS) Section H Continence Annual assessment which indicated bowel continence classified as "occasionally incontinent".

PointClickCare (PCC) assessments revealed an absence of a continence assessment when there was a change in a identified Resident's care needs.

Interview with the Director of Care on August 17, 2015, after reviewing PointClickCare and the hard copy chart confirmed the absence of a clinically appropriate continence assessment completed for the Resident upon a change in care needs. [s. 51. (2) (a)]

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 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, to be implemented voluntarily.

Issued on this 28th day of August, 2015

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

Original report signed by the inspector.