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 # / Registre no	Type of Inspection / Genre d'inspection
Nov 1, 2016	2016_325568_0023	029172-16	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

DOROTHY GINTHER (568), REBECCA DEWITTE (521)

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): October 24, 25, 26, 27, 2016.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Food Services Manager, Program Manager, Registered Dietitian, one Registered Nurse, two Registered Practical Nurses, one Dietary Aide, three Personal Support Workers, residents and their families.

The inspectors also toured the home, observed medication administration and medication storage; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, posting of required information; observed the provision of resident care, resident - staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 the planned care for the resident.

a) The most recent Minimum Data Set (MDS) assessment for resident #013 identified that the resident had a level one pain which was described as mild. The resident's diagnoses list indicated at least one condition which would be associated with pain.

During an interview with Registered Practical Nurse (RPN) # 103 they indicated that the resident occasionally suffered with pain and would require breakthrough pain medications and rest in-between activities.

During a review of resident #003's clinical record there were no documented

interventions with respect to pain and/or the condition it was associated with.

During an interview with RPN #103 they acknowledged that resident #003's plan of care did not set out the planned care for the resident with respect to pain.

b) Observations during the Resident Quality Inspection revealed resident #013 had an area of altered skin integrity.

During a review of resident #013's clinical record there was no documentation of treatments or interventions related to the identified area of altered skin integrity.

During an interview with the Registered Nurse (RN) # 102, they acknowledged that there was no written plan of care pertaining to the resident's altered skin integrity.

c) During stage one of the Resident Quality Inspection, RN #102 reported that resident #016 had a fall in the last 30 days.

Review of resident #016's clinical record indicated that a post fall assessment was conducted for the identified fall. The most recent Falls Risk Assessment Tool identified the resident as a low risk. There was no evidence of a written plan of care for resident #016 with respect to interventions to mitigate the resident's risk for falls.

The licensee failed to ensure that there was a written plan of care for resident #003 with respect to pain, resident #013 with respect to altered skin integrity, and resident #016 with respect to falls prevention. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident, the resident's Substitute Decision Maker (SDM), if any, and any other persons designated by the resident or SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

During an interview with resident #017's SDM, they shared that they were not being consulted prior to changes being made to the resident's treatment. The SDM reported two situations where the home had changed the resident's treatment before consulting with them.

a) Record review revealed a consultation note which included a recommendation to change resident #017's treatment. Documentation beside the recommendation indicated

that it would be processed on a specified date.

Review of the progress notes identified that the day before the treatment change was processed, resident #017's SDM contacted the home to ask if the consultation recommendations were available yet. The SDM was informed that they could not find anything, nor had they heard of any changes. The day after the order for the treatment change had been processed, the home contacted resident #017's SDM to notify them of the treatment change. Resident #017's SDM returned the home's phone call and was updated on the treatment change. The SDM expressed their concern regarding the treatment change at which point the home indicated that they would advise the physician of their concerns.

b) Record review revealed that on a specified date, a physician reviewed resident #017's treatments. Following the review, the physician ordered several treatment changes. The following day it was documented that a message was left for the SDM to call the home regarding changes to resident #017's treatment. The SDM returned the call within 24 hours, expressed their concern regarding the treatment change and asked for the change to be reviewed. The staff member advised the family that they would fax their concerns to the physician and await their response. Within a few days of the initial treatment change, documentation indicated that the physician had responded to the fax and had written a new order taking into consideration the SDM's concerns.

During an interview with RN #102 and the Director of Care #101, they were asked what the home's process was in terms of getting the resident and/or their SDM's consent for a change in treatment. RN #102 said that they would notify the resident or SDM when the order by the physician was written. In the case of treatment changes that were not an emergency, the staff were asked if they waited to get consent before proceeding with the order. RN #102 and DOC #101 indicated that it was not their practice to wait for consent prior to making the treatment change. In terms of resident #017, RN #102 acknowledged that they were not able to reach the SDM in either situation when the new treatment order was written and processed. On both occasions, RN #102 shared that the SDM had expressed concern about the treatment changes and felt they should have been consulted before they were made. The Director of Care agreed that while the SDM was notified of the change in treatment, they were not consulted prior to it being implemented. [s. 6. (5)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of resident #017's plan of care indicated that the resident was a moderate nutritional risk. Interventions to address the nutritional risk included a menu adjusted to meet the resident's health requirements and food preferences. Review of the Diet List book in the dining room identified food intolerances and several preferences for resident #017.

a) Review of the lunch menu for a specified dated indicated there were two meal choices. One of the meal choices included one of resident #017's food preferences. During the identified meal, resident #017 was observed to eat just one item on their plate. The remainder of the food was left. It was noted that resident #017 was not offered the menu item which was listed as one of their food preferences.

During an interview with the Food Services Manager (FSM) #106, they indicated that as part of the nutritional assessment for resident #017 they met with the resident's family to discuss food preferences. The FSM #106 acknowledged that the resident did not always eat well and they were trying to incorporate as many of their preferences into the menus. This inspector shared with FSM #106 that resident #017 had not eaten well at lunch that day. The resident had not been offered one of the food preferences identified on their plan of care, despite it being on the menu. The FSM #106 agreed that the plan of care with respect to food preferences should have been provided to the resident as outlined in the plan of care.

b) During observations on a specified date resident #017 was in bed sleeping. A glass of water was noted on the dresser beside the bed.

During an interview with PSW #110 they reported that they had already taken the nourishment cart down the hall where resident #017 resided. When asked if they had given resident #017 a snack that morning the staff member stated that there were no labelled snacks on the cart for resident #017. The staff member shared that any snacks on the morning nourishment cart were usually prepared and labelled. PSW #110 stated that they had left a glass of water for resident #017 as they were sleeping.

Review of the nourishment cart snack list for the specified date identified that resident #017 was to receive a labelled snack on the morning nourishment cart.

During an interview with the Registered Dietitian (RD) #112, they reported being aware of resident #017's food preferences and that the resident did not always eat well at meals.

These preferences had been recorded and included on the diet list and plan of care for resident #017. The expectation would be that the plan of care be followed in terms of these preferences in order to enhance the resident's intake. If the preferences were not available for some reason staff should try to substitute with something else that the resident might like. When asked about resident #017 not receiving a morning snack that day the RD#112 indicated that this might have been related to the availability of the item, but that in that situation something else should have been provided in its place.

The licensee failed to ensure that resident #017 was provided with food preferences as outlined in the plan of care. [s. 6. (7)]

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

During observations on a specified date, resident #016 was lying on their bed resting. The resident's bed was in the low position and there were no bed rails up.

Review of resident #016's plan of care related to falls risk and prevention identified a number of interventions to prevent falls.

Registered Practical Nurse #103 and #104 reported that resident #016 had more than one fall since their admission. The staff members indicated that they had trialed several interventions to prevent the resident from falling but found some of the strategies were not successful. These strategies had since been discontinued. When shown resident #016's plan of care related to falls, the staff acknowledged that they had not updated the plan of care when the fall prevention strategies had been discontinued when the resident's care needs changed.

The severity of harm for this area of noncompliance was identified as minimal harm with the potential for actual harm. The scope was a pattern as there were areas of concern with the plan of care on more than 33 per cent of the residents that we reviewed. This area of noncompliance was previously issued as a voluntary plan of correction on June 11, 2014 and August 9, 2015. [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 there is a written plan of care for each resident that sets out the planned care for the resident; that the resident / Substitute Decision Maker was provided the opportunity to participate fully in the development and implementation of the plan of care; that the care set out in the plan of care was provided to the resident as set out in the plan; and that the plan of care was reviewed and revised when the resident's care needs change or when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that they seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Review of resident council meeting minutes revealed there was no documentation that input or advice was sought from the Residents' Council in terms of the development of the satisfaction survey.

During an interview with the Resident Council Assistant, they indicated that the Residents' Council did not have the opportunity to provide input into the development and carrying out the satisfaction survey.

The Executive Director acknowledged that the Residents' Council had not had the opportunity to provide input into the development and carrying out of the satisfaction survey and it was the homes expectation that the Residents' Council have this opportunity.

The severity of harm for this area of noncompliance was minimal risk. The scope was isolated because less than 33 per cent of the residents in the home attended the Residents' Council meetings. The compliance history was a level two with one or more unrelated noncompliance in the last three years. [s. 85. (3)]

Issued on this 2nd day of November, 2016

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

Original report signed by the inspector.