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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: January 12, 2023

Inspection Number: 2023-1264-0004

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Trillium Court, Kincardine

Lead Inspector	**Inspector Digital Signature**
JanetM Evans (659)	Janet.M. Evans Digitally signed by Janet.M. Evans Date: 2024.01.24 13:57:14 -05'00'

Additional Inspector(s)
Mark Molina (000684)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 12, 13, 14, 15, 18, 19, 20, 21, and 22, 2023
The inspection occurred offsite on the following date(s): December 21, 2023

The following intake(s) were inspected:
- Intake: #00099299 - related to staffing, care and housekeeping.
- Intake: #00100661 - Critical Incident #2773-000021-23 related to alleged physical abuse of a resident
- Intake: #00101924 - Critical incident #2773-000024-23 related to COVID-19 Outbreak
- Intake: #00103057 - Critical incident #2773-000027-23 related to neglect of a resident by staff
- Intake: #00103374 - Critical incident #2773-000028-23 related to Improper care of a resident

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

Continence Care
Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services
Food, Nutrition and Hydration
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Staffing, Training and Care Standards
Restraints/Personal Assistance Services Devices (PASD) Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect

s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to ensure that a resident was protected from physical abuse. Section 2 (1) (b) of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

A resident had taken a co-resident's belongings. When the co-resident asked for their belongings to be returned, the resident became physically and verbally responsive towards the co-resident resulting in injury.

Failure of the home to protect the resident from a co-resident caused a resident to sustain injuries.

Sources: Resident progress notes, skin and wound assessments, risk management; Interviews with resident and staff
[000684]

WRITTEN NOTIFICATION: Administration of drugs

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary

A complaint received by the home and submitted to the Ministry of Long Term Care (MLTC) alleged a resident had medications administered inappropriately.

The home's policy for use of as needed (prn) medications directed the nurse

administering the medications to assess the resident before administration and document the assessment. They were also to document on the MAR/interdisciplinary progress notes: the date and time the prn was administered, the medication name, strength and dosage administered, the reason for the administration and its effectiveness and their signature was to be documented.

A) In October 2023, a medication was administered to a resident for a reason different from what it was prescribed for.

The RPN acknowledged the administration of the medication to help the resident remain calm, despite that this was not what the medication was prescribed for.

B) In November 2023, the resident was prescribed scheduled medications and as needed (prn) medications for a specific purpose.

There were two incidents in November 2023 where the resident was administered three prns at once. There was no documented monitoring or assessment of the resident at the time the medications were administered to show the purpose for administering it.

The resident was negatively impacted when these incidents occurred.

The Regional Clinical Manager stated based on their investigation the resident would not have warranted having the three prn medications administered at once.

Failing to properly assess a resident prior to the administration of medications and to follow the home's documented policies and procedures to ensure that medications were not administered for inappropriate purposes put the resident at risk of harm for over sedation and impacted their general health and wellness.

Sources: Complaint intake, resident records, LTC - Least Restraint Program, CARE10-O10.01, March 31, 2023, LTC - Emergency Restraint Use, CARE10-O10.02, March 31, 2023, LTC - PRN Medications – Administration and Documentation, CARE13-O10.05, revised March 31, 2023, Medication Administration Audit report dated Nov 29-30, 2023, November 2023 EMAR, home's investigation, interviews with ED, Regional Manager, RPN #112 and RPN #115.
[659]

WRITTEN NOTIFICATION: Documentation

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
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.

The licensee failed to ensure that the provision of care as indicated in a resident 's plan of care was documented

Rationale and Summary
The resident's plan of care documented the resident required assistance with all care.

Review of documentation survey reports for November 2023 showed many missing entries related to provision of assistance for ADLS of bed mobility, toileting, transferring, continence, dressing and hygiene and continence.

The ED acknowledged gaps in the documentation of care.

Sources: Complaint, Plan of care, Documentation survey report, interviews with ED and staff
[659]

WRITTEN NOTIFICATION: Binding on licensees

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
Binding on licensees
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee failed to ensure the Ministers Directives related to enhanced environmental cleaning during a COVID 19 outbreak, specifically related to high touch areas being cleaned a minimum of twice a day were followed.

Rationale and Summary
The home was declared in a COVID-19 outbreak in November 2023.

A complaint to Public Health in November 2023, reported that there was no enhanced cleaning of high touch areas during an outbreak.

There was one housekeeper/Personal Support Worker (PSW) working days during the outbreak. On numerous days during the outbreak they were pulled from housekeeping duties for a couple of hours to assist as a PSW.

The ED acknowledged enhanced cleaning which included high touch areas being cleaned a minimum of twice daily had not been completed.

Failing to follow the Ministers Directive related to enhanced environmental cleaning of high touch areas put residents and staff at risk related to transmission of infectious agents.

Sources: Complaint, Auditing, Revera Covid 19 playbook, Interviews with ED
[659]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

The licensee failed to ensure that resident #002 who required continence care products had sufficient changes to remain clean, dry and comfortable.

Rationale and Summary
A continence assessment for a resident, showed the resident's continence status changed and staff were to provide more frequent changes.

Observations completed did not show that staff were changing the resident as per their required frequency.

On four occasions, the resident was found in a manner which was not clean, dry and comfortable.

Failure to ensure the resident had sufficient changes to be clean, dry and comfortable may contribute to the resident's responsive behaviours and may lead to skin breakdown.

Sources: Complaint log, Plan of care, November 2023 Documentation survey report, Continence assessment December 9, 2023, CCRS dated September 12, 2023, SDM notes, interviews with PSW #113
[659]

WRITTEN NOTIFICATION: Therapy services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 65 (a)
Therapy services
s. 65 (a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs

The licensee has failed to ensure that a resident's assessed physiotherapy care needs, were arranged or provided by the licensee.

Rationale and Summary
A resident's care plan, documented the resident was to receive specific training and exercises twice a week.

The resident said there were times when they received less than two trainer sessions per week, due to staff shortages.

The Physiotherapist Aide (PTA) said the resident was unable to receive the specified training using the transfer trainer twice a week on certain weeks if they had no assistance, due to staff shortages.

Failure to follow the resident's care plan related to their physiotherapy care needs, put the resident at risk for decline in musculoskeletal function.

Sources: resident, and PTA and other staff; Resident's care plan [000684]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (d)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration

The licensee failed to ensure that staff implemented the homes nutrition care and hydration program specific to evaluating the food and fluid intake for a resident.

Rationale and Summary

A complaint to the ministry expressed concerns related to possible dehydration and missed meals.

The home's nutrition care and hydration program included a system where staff are to record resident's intake following meals.

Review of documentation survey report for November 2023 showed there were many missing entries where meals and snacks were not documented.

Failing to consistently monitor and record the resident's nutrition and hydration impacts the home's ability to manage and respond to nutritional and intake related concerns.

Sources: Complaint, Documentation survey report November 2023, PCC Weights, interviews with ED and DOC.
[659]

WRITTEN NOTIFICATION: Nutritional care and hydration programs

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and

The licensee failed to ensure that staff implemented the home's nutrition and weight management program with respect to monthly weights.

The licensee has failed to comply with the system to measure and record a resident's weight.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that there is a weight monitoring system to measure and record each residents' weight on admission and monthly thereafter and must be complied with.

Specifically, staff did not comply with the policy LTC - Weight Height Monitoring, CARE7-O10.03, reviewed March 31, 2023, which was included in the licensee's Nutrition and Hydration Program.

The home's policy for weight monitoring stated weights should be taken within a week of a resident's admission and monthly thereafter. They were to be recorded by the 7th of the month. If there was a 2 kg change in the weight, staff were to take the weight again.

Rationale and Summary

The admission weight for a resident was not recorded in PCC until two weeks later.

In the following three months, the weight was either not taken, a reweigh was not done when there was significant weight loss, and the weight was not recorded in PCC and not completed by the 7th of the month.

The dietitian acknowledged there were concerns about the accuracy of the resident weights as they did not indicate the actual date of weight. As well the dietitian sometimes had to request weights or re-weighs be done when they were not seen in PCC.

The DOC stated weights were to be taken and recorded immediately into the resident's record on PCC.

Failure to ensure weights were taken and recorded accurately and in a timely fashion may delay required interventions when significant changes were noted.

Sources: Electronic record PCC. hand written weight list from spa, LTC - Weight Height Monitoring,CARE7-O10.03, reviewed March 31, 2023, interviews with DOC and dietitian.
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WRITTEN NOTIFICATION: Housekeeping

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

The licensee failed to ensure that procedures were implemented for cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based

practices and, if there are none, in accordance with prevailing practices: for tubs and shower chairs .

Rationale and Summary
The home used Arjo disinfectant cleanser IV to disinfect the spa tub/chair.

Signage was posted in the tub room to identify the contact time for use of the disinfectant was 10 minutes.

Two PSWs were uncertain about the contact time for the disinfectant. One PSW thought it was around five to ten minutes and the other thought it was around five minutes. Neither said they actually left it on the tub for ten minutes.

The DOC and ED said the disinfectant was to be left on the tub for ten minutes.

Failing to ensure that the manufacturer's instructions for disinfecting the spa tub/chair put residents at risk for transmission of infectious organisms

Sources: Complaint, Spa signage, Arjo Disinfectant Cleanser IV directions for use, LTC Bath and Shower Guidelines CARE - 14-010.02 reviewed Mar 31, 2018, interviews with ED, DOC and staff.
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WRITTEN NOTIFICATION: Infection prevention and control program

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (15) 1.
Infection prevention and control program

s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.

The licensee of the home failed to ensure that there was an IPAC lead who worked a minimum of 17.5 hours a week in the role.

Rationale and Summary
The licensee's IPAC lead relinquished their role in November 2023 and went on leave from the home. The home did not have anyone working in the capacity of IPAC lead at the time of the inspection.

The home had an active COVID-19 outbreak for two weeks from November to December 2023.

Complaints were received related to the lack of cleanliness of the home, lack of hand sanitizer availability at the entrance to the home, and lack of high touch areas being cleaned during the outbreak.

There was no one providing IPAC oversight for the minimum number of hours for the length of the outbreak.

Failure to have a dedicated IPAC lead puts the home at risk for lack of oversight during outbreaks, lack of communication between the home and their public health partners and lack of follow up to ensure adherence with IPAC practices.

Sources: PHO compliant email, CIS complaint, interview with ED.
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