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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2019	2019_526645_0007	004333-19, 005561-19, 007825-19, 010232-19	Critical Incident System

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

Main Street Terrace
77 Main Street TORONTO ON M4E 2V6

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

DEREGE GEDA (645), DONNA TIERNEY (569)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 17, 18, 19, 20, 21 and 24, 2019.

The following critical incident system (CIS) with Log# 007825-19 related to responsive behaviour management and Log# 004333-19, 005561-19,and 010232-19, related to fall prevention and management, were inspected.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Resident Assessment Instrument (RAI) Coordinators, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers, (PSWs), Behavioural Support Ontario (BSO), Resident Care Co-ordinator (RCC), Housekeeping staff and Residents.

During the course of the inspection, the inspectors performed observations of staff and resident interactions, provision of care, reviewed residents' clinical records, staff training records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (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 :

The licensee failed to ensure that resident #001, #002 and #003 were reassessed and their plan of care revised when their care needs changed, or care set out in the plan were as no longer necessary.

1.Critical Incident System (CIS) was submitted to the Ministry of Long-Term Care. The report indicated that resident #001 had a fall and sustained an injury.

Record review of resident #001's current plan of care indicated that the resident was able to do self care on their own. Also, the resident was to ask for assistance when they required help during self care. Continued review of the resident's care plan indicated that the resident was to use an identified transferring device with the assistance of two staff members. Review of resident #001's current Kardex stated that the resident needs assistance during self care and when using the identified device. The Kardex also stated that the resident was able to do self care independently.

During an observation of resident #001's room, the inspector observed a logo that directed staff members to use the transferring device with two person assist.

During an interview with PSW #110, they shared that resident #001's current transfer method was a two-person assisted transfer. Previously the resident required the identified transferring device after their fall in February 2019 but did not require the device presently. PSW #110 was asked where they would find the information related to falls and transfer methods for resident #001. They replied they would obtain it from the nursing report when coming onto shift, the falling star and transfer logos that were posted in the resident's room, and from the electronic care plan and Kardex.

On an identified date, the Director of Care (DOC) #100, and the Assistant Director of Care (ADOC) #111 were interviewed. The DOC shared that a resident's care plan was updated quarterly and when a resident's care needs changed. It was the responsibility of registered staff and/or nursing management to update the care plan. Also, direct care staff obtained information on the specifics of a resident's care requirements from various sources including the electronic care plan and Kardex which they have access to from their tablets. Both were asked what the current method of transfer was for resident #001. They responded that the resident currently weight bears with two staff to assist in their transfer and do not require the identified transferring device. They both agreed the plan of care was not updated to reflect this.

The current plan of care for resident #001 was not revised when their care needs changed related to their transfer method.

2. CIS was submitted to the Ministry of Long-Term Care related to a fall with resultant injury for resident #002.

Record review of the resident #002's current written plan of care stated that staff were to remind the resident to use an identified mobility device and if needed bring the device to the resident and cue them to use it. Review of another section of the plan of care, it was documented that resident #002 benefitted from assisted ambulation and transfers. Also, there was a documentation stating that resident #002 currently use a different mobility device than the one identified above. These mobility interventions were also documented in resident #002's current Kardex .

During an interview, PSW #110 was asked where they would find the information related to mobility and ambulatory status for any resident. They replied they would obtain it from various sources including the electronic care plan and Kardex. When asked if resident #002 presently ambulated using the identified mobility device, PSW #110 said that the resident was not presently ambulating and does not use the identified mobility device. They stated that staff use a different type of mobility device than the one identified above.

During an interview, the DOC shared that a resident's care plan was updated quarterly and when a resident's care needs changed. It was the responsibility of registered staff and/or nursing management to update the care plan. Also, direct care staff obtained information on the specifics of a resident's care requirements from various sources including the electronic care plan and Kardex which they have access to from their tablets. When asked what was resident #002's current ambulatory status, the DOC responded that the resident currently was not ambulating and does not use the identified mobility device on the plan of care and agreed the care plan was not updated to reflect this.

The plan of care for resident #002 was not revised when their care needs changed related to their current ambulatory status.

3. CIS was submitted to the Ministry of Long-Term Care related to a fall with resultant injury for resident #003.

Record review of resident #003's current written care plan showed documentation that the resident required a device as an intervention to prevent fall.

An observation of resident #003's room was completed on an identified date. No device was found to be present.

During an interview, PSW #110 was asked where they would find the information related to fall interventions for any resident. They replied they would obtain it from various sources including the electronic care plan. When asked if resident #003 presently required the device, PSW #110 replied that they did not.

In an interview, the DOC and ADOC #111, stated that a resident's care plan was updated quarterly and when a resident's care needs changed. It was the responsibility of registered staff and/or nursing management to update the care plan. Also, direct care staff obtained information on the specifics of a resident's care requirements from various sources including the electronic care plan which staff have access to from their tablets. They were asked if resident #003's plan of care indicated the use of alarming device. ADOC #111 said that herself and the Physiotherapist installed the device for resident #003 upon return from hospital but the resident kept removing it, so the was discontinued. ADOC #111 acknowledged that the plan of care was not updated and revised to reflect this.

The plan of care for resident #003 was not revised when their care needs changed related to the discontinued use of the device. [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 residents are reassessed and their plan of care revised when their care need changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

Issued on this 1st day of July, 2019

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

Original report signed by the inspector.