Ontario

Ministry of Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère des Soins de longue durée

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Mar 9, 2020	2020_780699_0007	023541-19	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

PRAVEENA SITTAMPALAM (699)

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): February 25 and 26, 2020.

The following Critical Incident System (CIS) intakes were inspected:

-log #023541-19 related to resident choking incident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant DOC, registered dietitian (RD), registered nurse (RN), registered practical nurse (RPN), dietary aide (DA), recreation aide (RA), and personal support worker (PSW).

During the course of the inspection, the inspector observed staff to resident interactions and the provision of care, reviewed the home's policies, and conducted record review of residents' medical records.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services

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

2 WN(s)
2 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to resident #001 as specified in the plan.

The Director received a CIS report related to resident #001 choking while on an excursion outside of the home. The resident did not sustain any injury.

Record review of resident #001's plan of care, including the care plan, indicated the resident had a specific intervention related to their diet.

Record review of the home's "Trip Report and Itinerary", indicated that resident #001 had an identified diet. Further review of the document did not indicate that the resident required a specific intervention.

In an interview with recreation aide #103, they stated they would refer to the trip report or the people roster when on excursion to determine residents' diets when brought on an excursion by staff. They further indicated that they were not aware of resident #001's above mentioned intervention as it was not noted on the trip report or on the people roster that they had.

Review of the home's investigation notes stated that the diet information was not communicated to the dietary or recreation staff. Further review of the investigations showed that resident #001's dietary interventions were overlooked and as a result the cooks were notified of the intervention.

In interviews with ADOC #102, and Administrator #100, they indicated that resident #001 was provided a food item on the excursion that did not adhere to the specific intervention and subsequently choked. They acknowledged that resident #001's diet was not provided to resident #001 as specified in the plan of care. [s. 6. (7)]

2. The licensee has failed to ensure that staff and others who provide direct care to a resident were kept aware of the contents of the plan of care and given convenient and immediate access to it.

In an interview with PSW #112, they indicated that they would find information related to resident care on the care plan or Kardex.

Record review of the home’s “Trip Report and Itinerary”, indicated that resident #001 had a specific diet. Further review of the document did not indicate that the resident required a specific intervention.

In an interview with recreation aide #103, they stated the would refer to the trip report or the people roster when on excursion to determine the resident’s diet, which were brought on the excursions by staff. Recreation aide #103 stated that care plans or Kardex were not brought on the excursions.

In interviews with ADOC #102, and Administrator #100, they indicated that staff would have to call the nursing unit to obtain more information about the residents’ care needs if they are on excursion. The Administrator indicated that if the intervention for resident #001 was on the sheet, the recreation staff would have been able to identify the correct diet texture and given it to the resident. Following this incident, the home has implemented printing the lists from Synergy, which would include the residents substitutes and interventions. [s. 6. (8)]

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 care set out in the plan of care is provided to the resident as specified in the plan and that the staff and others who provide direct care to a resident are kept aware of the contents of the resident’s plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were monitored during meals, including residents eating in locations other than dining areas.

The inspector conducted a dining observation on February 25, 2020. Resident #003 was seated in the hallway adjacent to the dining room. The resident was observed at 1246 hours to be seated unsupervised in their mobility device in a tilted position, with their meal on bedside table in front of them.

Review of resident #003's care plan indicated that the resident required a specific level of assistance for meals and beverages at times, and required to be observed for difficulties swallowing or chewing.

The inspector spoke with RPN #108 at the nursing station at approximately 1247 hours. The RPN then walked over to the resident and at this point was joined by PSW #112. The PSW stayed with the resident for the rest of the meal.

In an interview with PSW #112, they indicated that they left the resident so that they could prepare the trays for the other resident. They acknowledged that they should not have left the resident unattended.

In an interview with RPN #108, they indicated that the resident should not have been left alone in the hallway. [s. 73. (1) 4.]

2. The licensee has failed to ensure that for resident #002, #003, and #004, proper techniques were used to assist residents with eating, including safe positioning of

residents who require assistance.

a. The inspector conducted a dining observation on February 25, 2020. Resident #002 was observed to be seated in an mobility device in a tilted position and was being fed an identified diet by a direct care staff at 1235 hours. The inspector approached RN #107 who was at the nursing station. The RN went to resident #002 and repositioned them into an upright position. The resident was fed the rest of their meal in an upright position.

In an interview with nursing student #109, they indicated that the resident should have been positioned in an upright position during meal times. They further indicated that the resident would be at risk for aspiration or getting fluid in their lungs if fed in a tilted position.

In an interview with RN #107, they indicated that residents should be seated in a 90-degree angle as the resident could be at risk for aspiration. The RN acknowledged that resident #002 was not positioned appropriately and provided immediate education to the nursing student.

b. Resident #003 was seated in the hallway adjacent to the dining room. The resident was observed at 1246 hours to be seated unsupervised in their mobility device in a tilted position, with their meal on bedside table in front of them. The resident was earlier observed being assisted with their meal by a PSW. The inspector spoke with RPN #108 at the nursing station at approximately 1247 hours. The RPN then walked over to the resident and at this point was joined by PSW #112. RPN #108 repositioned resident to an upright position.

In an interview with PSW #112, they indicated that residents should be seated in an upright position during meals. They acknowledged that resident #003 should not have been in a tilted position during meals.

In an interview with RPN #108, they indicated that resident should be seated in a 90 degree angle for meals.

c. Resident #004 was observed to be seated in a mobility device in a tilted position and was being fed a specific diet by a direct care staff who was standing at 1235 hours. The inspector approached RN #107 who was at the nursing station. The RN went to resident #003 and repositioned them into an upright position and provided the PSW a chair to sit on. The resident was fed in an upright position with the PSW seated for the rest of their

meal.

In an interview with RN #107, they indicated that residents should be seated in a 90-degree angle as the resident could be at risk for aspiration. The RN acknowledged that resident #003 was not positioned appropriately and staff should not be standing and feeding a resident.

In an interview with RD #104, they indicated that all residents, regardless of their diet, must be fed in a 90-degree position. They further indicated that residents could be at risk for aspiration and choking if not properly positioned.

In an interview with ADOC #102, they acknowledged that residents #002, #003, and #004 were not appropriately positioned when assisted with their meals. [s. 73. (1) 10.]

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 proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 10th day of March, 2020

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

Original report signed by the inspector.