Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Jul 16, 2019	2019_591623_0006	024126-17, 026055-17, 027424-17, 001527-18, 007087-18, 020740-18	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

ReachView Village
130 Reach Street UXBRIDGE ON L9P 1L3

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

SARAH GILLIS (623)

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 4, 5, 6, 7, 11, 12, 13 and 14, 2019

The following intakes were inspected concurrently:
Log #007087-18 - for Critical Incident Report related to outbreak
Log #001527-18 - for Critical Incident Report related to outbreak
Log #024126-17 - for Critical Incident Report related to outbreak
Log #020470-18 - for Critical Incident Report related to fall with injury
Log #027424-17 - for Critical Incident Report related to fall with injury
Log #026055-17 - for Critical Incident Report related to allegation of neglect

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of care set out in the plan of care is documented.

Log #026055-17

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of neglect that involved residents #002 and #003, who were both receiving palliative care in the home at the time. Resident #003 deceased on a specified date and resident #002 deceased two days later. The CIR indicated that an email was received by the Executive Director (ED), Director of Care (DOC) and Assistant Director of Care (ADOC) on a specified date from RPN #110 regarding residents who had been receiving palliative care, that identified concerns about the required care not being provided by RPN #111. The licensee immediately began an investigation.

Review of the initial email indicated the following:

The email was sent on a specified date by RPN #110 to the ED, DOC and ADOC but was not received until two days later. The email indicated that on a specified date during a specified shift resident #003 had a fever. The resident was given medication for the fever and for pain management end of life care by RPN #110. Report was given to the next shift nurse RN #111. When RPN #110 returned to work the following day resident #003 had passed away. RPN #110 identified that during the night shift that RN #111 worked, resident #003 did not receive any medication for pain or fever. There was no documentation by RN #111. The RN on the following shift documented that resident #003 had a fever when they assessed the resident at the beginning of their shift. The email also identified resident #002 who was receiving end of life palliative care but did not receive as needed pain medication and there was no documentation by RN #111 on the specified date. The next shift RN documented that they received the resident in visible pain and administered pain medication. RPN #110 expressed their concerns regarding the lack of palliative care and comfort measures that were provided to resident #002 and #003 and requested that management look into the matter. At the time the email was sent, both residents had already passed away.

Review of the licensee's internal investigation was completed and indicated the following:

Video footage of the hallway outside of resident #003's room on a specific identified date indicated that RN #111 entered the resident's bedroom and exited the room 32 seconds later. The RN entered the room a second time and exited ten seconds later. In both

instances the RN was not carrying any equipment in order to complete an assessment or provide any medications. The licensee determined that given the length of time the RN was in the resident's room a combined total of 42 seconds during the entire eight hour shift, it was not possible that the RN was able to complete an assessment of resident #003. A review of the clinical record including progress notes and electronic medication record, revealed that there was no documentation by RN #111 for resident #003 that shift, and there was no medication signed as administered.

During an interview with Inspector #623, the ED indicated that during the licensee's investigation, video footage of the hallway outside of resident #002's room was also viewed for the identified shift on a specified date but this video was no longer available. The ED indicated that the footage revealed that RN #111 did enter resident #002's room on two occasions throughout the shift and each time was for approximately five minutes. The ED indicated that it was possible that RN #111 was in the resident room on each occasion, a length of time where is was possible that an assessment could have been completed.

Review of the progress notes and electronic medication record for resident #003 indicated that on a specified date and time, RPN #110 documented an assessment as well as medications that were administered to resident #003 for pain and fever. RPN #110 reported off to RN #111 at a the change of shift. There was no documentation for resident #003 by RN #111 during their eight hour shift. On the shift following RN #111, RN #112 administered medication for a fever, as well as medication for pain and excessive secretions.RN #112 documented that upon assessment of resident #003 at the beginning if the shift, the resident had a fever and difficulty breathing. Medications were administered as ordered for comfort.

Review of the progress notes and electronic medication record for resident #002 indicated that on a specified date and time, RPN #117 documented an assessment of resident #002 which indicated that palliative care had been provided every two hours, the resident appeared comfortable and there were no signs of distress. There is no documentation by RN #111 during their shift on a specific identified date and time. On the shift following RN #111, RN #112 documented that they administered medication for pain to resident #002 at the beginning of their shift. RN #112 administered a second dose of pain medication one and a half hours later for continued pain. Resident #002's respirations ceased two hours later. Prior to RN #112 administering pain medication, resident #002 had not received pain medication for an extended period of time.

The licensee's internal investigation notes indicated that an interview took place with RN #112 on a specified date which indicated that on the identified date when they arrived for their shift, RN #111 indicated in shift report that resident #003 was palliative but no further information was provided. When RN #112 went to assess resident #003, they described the resident to appear distressed and the resident had a fever.

During an interview with Inspector #623, RN #112 indicated that they did not recall receiving much of a report from RN #111 on the identified date. RN #112 indicated that they began rounds following report and started with resident #002 because they were also palliative. Resident #002 was congested, had a fever and pain. RN #112 administered medications to resident #002 and then went to assess resident #003. RN #112 recalled that resident #003 was restless, they appeared to be in a lot of pain. The resident had a fever but RN #112 was not told this in report. RN #112 administered medications to help with pain, reduce the fever and to dry the secretions. The resident was very congested, and was in a panic. RN #112 indicated that they reviewed the progress notes for resident #003 and there was no documentation by RN #111 from the previous shift. RN #112 indicated that the resident had not received any medication for pain or fever 12 hours. RN #112 indicated that on the morning of a specified date resident #002 was continuing to receive end-of-life care. The RN indicated that when they went to assess resident #002, they appeared to be in extreme pain. The RN administered pain medication and repeated it again at one and a half hours later to try and make the resident comfortable. RN #112 indicated that there had been no documentation on the previous shift to indicate that RN #111 had assessed resident #002, and the resident had not received any medications for an identified period of time, however there was documentation by the RN's on two other shifts to indicate an assessment was completed, care was provided and the resident was comfortable.

RN #111 was not available for interview during the inspection.

During an interview with Inspector #623, the DOC indicated that during the licensee's investigation interview, RN #111 indicated that an assessment was completed for resident #002 and #003 but the assessments were not documented. The DOC indicated that the expectation of the licensee is that all care including assessments is documented in the resident's electronic record in Point Click Care (PCC).

The licensee failed to ensure that the provision of care set out in the plan is care is documented for residents #002 and #003. [s. 6. (9) 1.]

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 by ensuring that the provision of care that is set out in the plan of care is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident receives end-of-life care when required in a manner that meets their needs.

Log #026055-17

A critical incident report (CIR) was submitted to the Director on a specified date for an allegation of neglect that involved residents #002 and #003, who were both receiving palliative care in the home at the time. The CIR indicated that an email was received by the ED, DOC and ADOC on on a specified date from RPN #110 regarding residents who had been receiving palliative care, that identified concerns about the required care not being provided by RPN #111. The licensee immediately began an investigation.

Review of the progress notes and electronic medication record for resident #003 indicated that on a specified date, RPN #110 documented an assessment as well as medications that were administered to resident #003 for pain and fever. RPN #110 reported off to RN #111 at the change of shift. There was no documentation for resident #003 by RPN #111 during their shift. On a specified date and time RN #112 administered medication for fever, pain and excessive secretions to resident #003. The documentation indicated that upon assessment at the beginning if the shift, resident #003 had a fever and difficulty breathing. Palliative care was provided.

Review of the progress notes and electronic medication record for resident #002

indicated that on a specified date and time, RPN #117 documented an assessment of resident #002 which indicated that palliative care had been provided every two hours, the resident appeared comfortable and there were no signs of distress. There is no documentation by RPN #111 during their specific identified shift. On a specified date and time, RN #112 documented that they administered medication for pain. RN #112 administered a second dose of pain medication one and a half hours later for continued pain. Resident #002 had not received pain medication for a number of hours.

Review of the written plan of care in Point Click Care (PCC) for resident #002 identified that an end-of-life plan was implemented on a specified date which included providing medications for comfort as ordered and to monitor for pain including completion of a pain flow sheet. Assess for any change in skin colour, temperature, or mottling as well as any changes in breathing pattern, moist & gurgling breathing or changes in level of consciousness, and this was to be reported. Provide repositioning and mouth care every two hours, as well as staff were to notify the nurse of any changes in the breathing pattern including moist or gurgling breathing or changes in the level of consciousness.

Review of the written care plan in PCC for resident #003 identified that an end-of-life plan was implemented on a specified date which included providing medications for comfort as ordered and to monitor for pain. Assess for any change in skin colour, temperature, or mottling as well as any changes in breathing pattern, moist & gurgling breathing or changes in level of consciousness, and this was to be reported. Staff were also to report any restlessness or anxiousness. Comfort care measures including, bathing, moisturizing, turning, continence care and oral care were to be provided at least once per shift and also as often as required.

Review of the licensee's internal investigation was completed and indicated the following:

Video footage of the hallway outside of resident #003's room on a specified date indicated that RN #111 entered the resident's bedroom at a specified time and exited the room 32 seconds later and again at a specified time and exited ten seconds later. On both instances the RN was not carrying any equipment to complete an assessment or any medications. The licensee determined that given the length of time the RN was in the resident's room a combined total of 42 seconds during an eight hour shift, it was not possible that the RN was able to complete an assessment of resident #003 in that length of time. A review of the clinical record including progress notes and electronic medication record, revealed that there was no documentation by RN #111 for resident #003 that shift, and there was no medication signed as administered.

During an interview with Inspector #623, the ED indicated that the licensee's investigation also included video footage of the hallway outside of resident #002's room that was also reviewed for the identified shift on a specified date but this video is no longer available. The ED indicated that the footage revealed that RN #111 did enter resident #002's room on two occasions throughout the shift and each time was for approximately five minutes. The ED indicated that it was possible that RN #111 was in the resident room on each occasion, long enough that an assessment could have been completed but there was no documentation to support this.

RN #111 was not available for interview during this inspection.

During an interview with Inspector #623, RPN #114 indicated that when a resident is deemed palliative the registered staff meet with the resident's family to make the plan for their end-of-life care wishes. A call is placed to the physician for end-of-life care orders including medications to keep comfortable, orders for hydration and nutrition if appropriate. The care plan is updated by the RPN to include end of life measures specific to that resident's needs and wishes. RPN #114 indicated that there is a palliative care room available in the home, but only one, the resident can be moved to so that the family can have privacy. If this room is not available, then all effort is made to ensure privacy and comfort for the resident and their family. RPN #114 indicated that the family is permitted to stay with the resident 24 hours a day, there are no restrictions on visiting.

During an interview with Inspector #623, RN #115 indicated that when a resident is receiving palliative care this information is communicated to the RN during report at the change of shift. The RN indicated that when the resident has a change in condition the RN notifies the physician and meets with the family to discuss their wishes. A palliative plan was put into place for resident's #002 and #003, which included medication orders, and palliative care measures such as turning, positioning, mouth care, pain management, comfort measures. The RN indicated that when a resident becomes palliative, their expectation is that the resident will be observed at least hourly and personal care provided every two hours at minimum. The RN indicated that if a medication is given, they always return within 30 minutes to evaluate effectiveness. The RN indicated that there is a palliative orders template sheet that the physician will use and customize according to the resident's individual needs. The RN indicated that at the minimum an assessment of the resident should be documented each shift, and any care that is provided including medications, would also be required to be documented in the progress notes in Point Click Care (PCC).

During an interview with Inspector #623, the DOC indicated that following the licensee's internal investigation it was determined that the accusations surrounding end-of-life care for resident #003 were validated, since the video footage revealed that not enough time was spent in the room for RN #111 to complete an assessment. The accusation related to resident #002 could not be determined since the video footage did show that the RN was in the room longer. It could not be determined if the RN completed an assessment, they did however fail to document if an assessment had been completed. The DOC indicated that during the licensee's investigation interview, RN #111 indicated that an assessment was completed for resident #002 and #003 but the assessment was not documented.

The licensee failed to ensure that every resident receives end-of-life care when required in a manner that met the needs of resident's #002 and #003. [s. 42.]

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 by ensuring that every resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

Issued on this 25th day of July, 2019

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

Original report signed by the inspector.