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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 30, 2014	2014_293554_0029	O-000273-14	Complaint

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

REACHVIEW VILLAGE
130 REACH STREET, UXBRIDGE, ON, L9P-1L3

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

KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 21-22, 2014

Specific to Log #O-000273-14

During the course of the inspection, the inspector(s) spoke with Executive Director, Assistant Director of Care, Registered Nursing Staff, Personal Support Workers, Physiotherapist, and Family

During the course of the inspection, the inspector(s) tour of the home, review of clinical health record relating to Resident #001, incident investigation notes specific to inspection, the home's policy relating to Lifts and Transfers, Falls Prevention and Management and Pain Management, and reviewed staff training records specific to Falls Prevention and Management

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Pain
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The license failed to comply with LTCHA, 2007, 6. (1), by ensuring there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve.

Resident #001 sustained an injury during care; resident complained of pain following the incident.

Progress notes for the period reviewed, indicate pain medication was provided to the resident, but of little to no effect in managing the symptoms.

The written care plan for the above time period did not identify pain as an area of concern for this resident.

2. The licensee failed to comply with LTCHA, 2007, s. 6. (2), by ensuring that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Resident #001 sustained an injury during care.

Progress notes for the period reviewed, document Resident #001 as being in a pain as a result of the incident; notes indicate pain medications given were ineffective.

According to the progress notes, Resident #001 requested to be transferred to the hospital on two separate occasions due to pain symptoms; resident was not transferred to the hospital until approximately twelve hours after the initial request.

The Health Care Directives for this resident directs the home to, transfer resident to an acute care hospital without CPR for assessment and or treatment.

During an interview, Assistant Director of Care indicated Resident #001 was not sent to hospital on the date specified as resident was always asking to go to the hospital and staff assumed resident could be cared for in the home. [s. 6. (2)]

3. The licensee failed to comply with LTCHA, 2007, s. 6 (11)(b), by ensuring the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective.

Resident #001 complained of pain following a care incident.

Progress Notes for the period reviewed indicate that Resident #001 was given pain medications on several occasions over a twelve hour period, notes indicate pain medication to be ineffective; resident as per the progress notes was awake the majority of the shift, and continued to complain of discomfort.

There is no indication in the progress notes or physician's orders of registered nursing staff contacting the resident's physician or an on call doctor when pain medication was ineffective.

The home's policy, Pain Assessment and Symptom Management (LTC-E-80) directs that the Physician or Nurse Practitioner is to be notified when resident reports sudden onset of new pain or worsening of pain.

Assistant Director of Care indicated a doctor should have been contacted when medications for pain were ineffective. [s. 6. (11) (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 process in place to monitor that written care plans, identify the planned care for each resident and the goals the care is intended to achieve; the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; and ensuring the resident is being reassessed and the plan of care is being revised because care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 23, by ensuring staff use all equipment, devices and positioning aids in accordance with manufacturers' instructions.

Resident #001, sustained an injury during care, when staff were utilizing specific equipment with this individual; resident was later transferred to hospital and admitted for treatment.

In a written statement, Staff #108 indicated that the specific equipment utilized was not used according to manufacturer instructions nor as specified by the home's practice and or policy.

A review of the Operating and Product Instruction for the equipment used indicated the following:
- Page 8 – Lower leg straps are an accessory used to ensure that the lower parts of the resident's legs stay close to the knee support. Ensure that leg strap is firm but comfortable for the resident.
- Page 9 – indicates 'Caution' (in bold print) – An assessment will have to be made whether the resident requires the lower leg straps. Apply if necessary.

Assistant Director of Care (ADOC) indicated that the lower leg strap is to be used for all residents when using the indicated equipment, as such is the practice of the home.

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 process in place to monitor that all staff are using equipment, supplies, devices, assistive aids and positioning aids in accordance with manufacturers' instructions. The licensee will further ensure that if the home's policy or practice supersedes the instructions provided by the manufacturer that there is a process in place to communicate direction to the staff using the equipment or device and such is documented as communicated and training provided, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 36, by ensuring that staff use safe transferring and positioning devices or techniques when assisting residents.

The home reported, Resident #001 as having sustained an injury while staff were using a transferring device with this resident; the resident was later transferred to the hospital and was admitted.

The home's policy, Mechanical Lifting and Transferring Devices (HS-P-80) directs that two (2) staff must be present at all times when the lift is in operation to ensure safety and follow through of all procedures.

During the home's investigation, Staff #107 indicated Staff #108 left the room to obtain supplies, while the resident was still in the transferring device. Staff #107 indicated Staff #108 was gone several minutes.

2) During the home's investigation of incident involving Resident #001, Staff #108 indicated in a written statement that the lower leg strap was not fastened during the transfer of this resident.

Staff #106, who provides education to direct care staff, as to the safe use of transferring devices indicated it is the home's policy and practice to at all times fasten the lower leg strap whenever a resident is being transferred using the specified equipment.

Assistant Director of Care indicated all staff are to use the lower leg strap for all residents when using the identified equipment as such is the practice of the home.

3) Relating to the incident involving Resident #001, a written statement by Staff #108 indicated that the resident was uncooperative and that staff continued with care and transfer which subequently resulted in a fall.

The home's policy, Assessment for Lifting and Transferring (HS-P-50) directs that a

resident's functional ability will be reviewed by the caregiver prior to performing a resident manoeuvring task to determine if the planned manoeuvring activity can be performed safely.

Staff #106, a member of the S.A.L.T Team responsible for educating direct care staff as to safe use of transferring equipment, indicated staff are trained that if and when a resident becomes uncooperative when using a transferring equipment, the resident is to be immediately lowered back into the chair, wheelchair or onto the bed. [s. 36.]

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 there is a process in place to monitor staff compliance with policy, practice and training specific to safe transferring and the use of positioning devices or techniques when assisting residents. The licensee will further ensure that direct care staff are aware of and empowered to report all non-compliance with the home's policy and practice relating to the use of equipment, specifically as it relates to use of mechanical lifts, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 52 (2), by ensuring when a resident's pain is not relieved by initial interventions, that the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Progress notes reviewed for the specific time period indicate Resident #001 voicing complaints of pain.

Progress notes written by registered nursing staff indicate pain medications administered were of little effect; resident was unable to sleep and continued to call out as a result of pain symptoms.

A review of Resident #001’s health record failed to provide evidence that a Pain Assessment was completed during this period.

O. Reg. 79/10, s. 52 (2), was previously issued to the home; during a follow up inspection, the home was able to demonstrate improvement in practices relating to Pain Assessment and Management and was placed back into compliance.

Resident #001 is not longer residing at the home. [s. 52. (2)]

Issued on this 22nd day of August, 2014

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