Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 3, 4, 5, 10, 26, 27, May 2, 3, 4, 2012	2012_070141_0005	Critical Incident

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

WEST OAK VILLAGE
2370 THIRD LINE, OAKVILLE, ON, L6M-4E2

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

SHARLEE MCNALLY (141), LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Regional Director Labour Relations, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) reviewed resident's records, home's investigation notes, staff education records, identified staff personnel records, licensee policy and procedure related to continence program, pain management, and abuse.

Log #000607-12

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Pain

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure the plan, policy, protocol, procedure, strategy or system related to pain management was complied with for an identified resident. The resident was assessed as experiencing no pain at the time of admission but the resident had pain medication administered as needed following adission. The resident received pain medication as needed over a 2 month period. The home's policy "Pain Assessment and Symptom Management - Assessment/Monitoring Instruments" (LTC-N-60) stated that all residents will be assessed for pain. They will be consistently and systematically monitored for pain which will include a quick pain assessment of the resident using "RQRST" assessment. The resident had no assessment of their exhibited pain completed. Incomplete templates of the pain assessment forms were in the resident's records. The Director of Care confirmed that pain assessments for the resident should have been completed.
2. The licensee did not ensure the plan, policy, protocol, procedure, strategy or system related to continence care was complied with for an identified resident. The policy "Bowel and Bladder Continence Care Program Implementation" (LTC -N-05) stated the Admission and/or Situational Toileting Pattern for Bowel/Bladder will be initiated along with the Bowel and Bladder Monitoring Record as a component of the Minimum Data Set (MDS) observation seven day monitoring. The resident records did not include an assessment or 7 day monitoring record to identify resident continence status.

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 instituted plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following subsections:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure their written policy to promote zero tolerance of abuse and neglect of residents was complied with for an identified resident. The policy "Resident Non-Abuse" (LP-B-20-ON) stated any employee or person who becomes aware of, and/or has reasonable grounds to believe, an alleged, suspected or witnessed resident incident of abuse or neglect will report it immediately to the Executive Director or, if unavailable, to the most senior supervisor on shift at that time. An employee of the home did not report immediately to their supervisor their knowledge of an alleged incident of abuse toward a resident.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. An identified resident's documentation did not include all assessment and reassessment for every use of a physical device to restrain the resident. The resident had an order for a physical restraint to be applied as needed. The resident records demonstrated the resident was physically restrained on occasion for a 2 month period in 2012.
There was no documentation in the resident progress notes or Restraint Monitoring Record on 16 occasions to indicate an assessment or reassessment was completed by a physician, registered nurse in the extended class, or a registered nursing staff for each occurrence of the application of the physical restraint as in accordance with Regulation 110.(2)6 .

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee did not ensure for each resident demonstrating responsive behaviours that strategies are developed and implemented to respond to these behaviours, where possible. Developed strategies were not implemented to respond to an identified resident when demonstrating responsive behaviours. The resident exhibited behaviours frequently and the physician had ordered medication when required for the responsive behaviours. Medications were not offered consistently, although the resident continued to exhibit responsive behaviours. Documentation in the resident records did not indicate the strategy of pharmacological interventions was offered to the resident. Nursing staff confirmed they did not offer medication to the resident consistently.
2. The licensee did not ensure that written approaches to care, including screening protocols, assessment and reassessment and identification of triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. Written approaches for care developed to meet an identified resident's needs in response to responsive behaviours did not include all known triggers. The current Resident Assessment Protocol (RAPs) identified the resident demonstrated responsive behaviours of care almost every day. The written plan of care did not identify the known triggers or include strategies to minimize the specific behaviours. Not all responsive behaviours were identified in the written plan of care. Nursing staff were able to identify some triggers for responsive behaviours not included in the plan

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 for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not immediately report the suspicion of abuse of a resident by anyone and the information upon which it was based to the Director. The home's management was informed of an allegation of abuse towards an identified resident. The licensee did not inform the Director immediately of the alleged abuse. The Administrator confirmed there was a delay in reporting the alleged incident to the Director.

WN #6: 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 subsections:

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. An identified resident was not reassessed and their written plan of care was not reviewed and revised at the time when the resident's care needs changed. The physician ordered a revision in the type of physical restraint being used for the resident. The resident's records did not include a reassessment of the need for change in the type of physical restraint to be applied, and the written plan of care was not revised to include the change in the type of restraint.
2. An identified resident was not reassessed and the plan of care reviewed and revised when the resident care needs changed. The resident was assessed as experiencing no pain at the time of admission but their records indicated expressions of pain after this initial assessment. The resident was initiated on pain medication in response to expressed pain. The resident had no reassessment of their exhibited pain completed and a plan of care was not developed to identify strategies to address the pain.

Issued on this 25th day of June, 2012

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