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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 29, 2014 | 2014_340566_0013 | T-1059-14 | Critical Incident System |

**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**

WESTSIDE
1145 Albion Road, Rexdale, ON, M9V-4J7

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

ARIEL JONES (566), JOANNE ZAHUR (589), SARAN DANIEL-DODD (116), SLAVICA VUCKO (210)

**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): August 18, 19, 21, 22, 25, and 26, 2014.**

**This inspection was performed in conjunction with the Resident Quality Inspection (RQI), T-115-14 (#2014_378116_0008). Additional findings of non-compliance have been cited in that report.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), registered nursing staff (RN/RPN), personal support workers (PSW), the resident, the resident's Power of Attorney (POA) and family, and a detective from Toronto Police Services.**

**During the course of the inspection, the inspector(s) conducted resident observations, reviewed relevant home records, relevant policy and procedures, and resident health records.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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 licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review of resident #037's care plan indicated that the resident prefers showers, and requires assistance of one staff member for bathing. A review of the resident's flow sheets revealed that the resident consistently refused his/her scheduled showers over an identified two month period.

An interview with an identified registered nurse confirmed that the home's practice and expectation is for the PSW staff to report any refusals of care to the registered staff. The registered staff member confirmed that the resident's bathing refusals were mostly related to having unfamiliar staff providing care. Furthermore, the registered staff confirmed that the PSWs did not consistently report the above mentioned refusals in order to enable the nurse to update the care plan with appropriate interventions. [s. 6. (4) (a)]

2. The licensee has failed to ensure that when a resident is reassessed and the plan of care is being revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

A review of the written plan of care for resident #037 indicated that the resident had been identified as being at risk for falls, as evidenced by impaired balance and unsteady gait. The resident's care plan was later revised after multiple falls to include addiction to an identified substance as an additional risk. Some of the interventions outlined to prevent further falls were: falling star logo to identify high risk residents, call bell to be within reach, and frequent reminders for the resident to call for assistance before getting up.

Review of the post-fall documentation indicated that the resident had a fall on an identified date in his/her bathroom, and was found possibly intoxicated and using inappropriate language toward staff. On a second identified date the resident had a fall in his/her room, whereby the registered nurse documented that the resident was seemingly intoxicated and confused post-fall. On a third specified date, the resident had two falls an hour apart. The post-fall progress notes indicated the resident was confused, drowsy and verbally aggressive. An interview with the registered nurse confirmed that on the third identified date, the resident was intoxicated, and during a search of his/her room several empty containers of an identified substance were found. A falls risk intervention for staff to check the resident's room for the identified substance was added to the resident's written care plan after the two falls that occurred on the third identified date.

The resident was not reassessed and the plan of care was not revised after the first two identified fall incidents, and different approaches to prevent further falls were not considered in the revision of the plan of care. [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 that the plan of care provides the following:***
***1. that the staff and others involved in the different aspects of the care of the resident collaborate with each other so that their assessments are integrated and are consistent with and complement each other,***
***2. that if the plan of care is being revised because the care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A review of resident #037's clinical record and interviews with PSWs and an identified member of the registered nursing staff indicated that on an identified date the PSW reported to the evening registered nurse that resident #037 had a big blackish/bluish bruise on an identified area of the body. The identified registered nurse confirmed that he/she had documented the bruise in the resident's progress notes.

An interview with an identified member of the registered nursing staff indicated that when a resident exhibits altered skin integrity, the skin is assessed and the assessment is documented in the electronic documentation system using the head to toe assessment form.

A review of the clinical record and interview with an identified member of the registered nursing staff confirmed that when the resident experienced altered skin integrity, a skin assessment was not performed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

***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 resident exhibiting altered skin integrity receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**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; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(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 failed to ensure that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

Record review revealed that resident #037 demonstrated the following incidents of responsive behaviours:
- On an identified date, the resident was observed to have stripped, scattered items in his/her room, and refused caregiver assistance.
- On a second identified date, the resident was confused and found naked in his/her room, using inappropriate language toward staff.
- On a third identified date, the resident appeared confused, took off all his/her clothes, and went naked into the hallway yelling for help.

An interview with an identified registered nurse confirmed that the resident exhibits behaviours related to stripping off his/her clothes and refusing care.

Further review of resident #037's written plan of care confirmed that it does not identify strategies to address these behaviours. [s. 53. (4) (b)]

**Issued on this 17th day of October, 2014**

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