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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2017	2017_631210_0010	026087-16, 005326-17, 009369-17, 010022-17, 010540-17	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

SLAVICA VUCKO (210), CECILIA FULTON (618), GORDANA KRSTEVSKA (600), THERESA BERDOE-YOUNG (596)

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): June 15, 16, 19, 20, 21, 22, 23, 26, 27, 28, 30, July 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, and 20, 2017.

The following complaint intakes were inspected:
Related to Plan of Care, Laundry Service: Log # 026087-16, 010022-17, 010540-17
Related to Residents' Bill of Rights: Log # 005326-17
Related to Menu Planning, Administration of Drugs Log #009369-17

During the course of the inspection, the inspector(s) spoke with the acting Executive Director (ED), Director of Nursing Care (DONC), Assistant Director of Nursing Care (ADONC), Staff Educator, Social Worker (SW), Registered staff, Resident Care Coordinator (RCC), Personal Support Workers (PSWs), Registered Dietitian (RD), Food Service Manager (FSM), Dietary Aids (DA), Environmental Services Manager (ESM), Housekeeping Staff, Physiotherapist (PT), Recreation and Activation, Program Manager, Recreation Program Assistants, Resident(s) and Substitute Decision Maker(s) (SDM).

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A complaint and Critical Incident Report (CIR) were submitted to Ministry of Health and Long Term Care (MOHLTC) on a specific date, in relation to resident #026's fall on an identified date in 2017, that caused an injury to the resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

A review of resident #026's clinical record revealed he/she was admitted on an identified date in 2017. The resident had specified diagnoses such as history of falls. A review of the incident reports revealed the resident had an unwitnessed fall on an identified date. The registered staff initiated an identified assessment tool after the fall. The form indicated the resident to be assessed at specified intervals of time over a specified time period. The assessment flow sheet revealed assessments were not conducted for the duration of the time intervals. Interview with registered nurse staff #102 revealed when a resident has a fall that is not witnessed; the resident assessment should be documented on the identified assessment flow sheet for the duration of time specified.

According to resident #026's SDM interview he/she was informed about the fall on the following day. The registered staff informed him/her that the resident seemed fine during the day shift. When he/she arrived at the home he/she observed the resident in bed and reported that according to him/her the resident presented differently than usual; with impaired skin integrity on two parts of the body.

Interview with registered staff RPN #109 revealed he/she took the vital signs the day after the fall, but he/she did not document in the chart or the Flowsheet. ADOC staff #150 revealed the expectation is if a Flowsheet assessment form was initiated it had to be completed over the specified time period hours and confirmed that the same was not completed for resident #026. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident.

This inspection was triggered by a complaint submitted to MOHLTC in regards to a lost item.

A review of resident #025's written plan of care revealed the resident had a specified device, and that staff are to apply it on the resident in the morning. Staff are also directed to check the room for the specified device before discarding the linen because of resident's history of throwing the device away. Staff were also expected to ensure that

the device was in place during the day and certain activity of everyday living.

A review of the progress notes revealed on an identified date in the evening, the resident remained cooperative throughout the shift, however he/she refused to give the device to the PSW when he/she approached to remove them. On another specified date, the progress notes revealed part of the resident's device was missing. The other part was found in the resident's room. Interview with registered staff RPN #141 revealed that there was no clear direction regarding where the device was to be kept once removed from the resident.

Interview with registered staff RPN #141 revealed that approximately one month ago resident #025 went on leave of absence (LOA) with the family and came back with one part of the device in a plastic bag because the SDM reported the device was uncomfortable. RPN #141 did not document this anywhere or communicate any concerns regarding the device problems identified by the SDM and did not have any conversation with the SDM regarding his/her preferences on how to proceed with the use of the device.

RPN #141 revealed that he/she was aware that the SDM had arranged an assessment with a specialist; however the outcome of this assessment was not communicated to the home.

RPN #141 further revealed that the resident had a history of responsive behaviour such as removing the device.

Interview with PSW #125 revealed that in the last couple of months the resident had been removing the device frequently because they were hurting him/her. According to PSW #125 he/she did not apply the device for two days because the resident was constantly removing it once applied. PSW #125 revealed there were times when he/she found the device in other areas of the unit. PSW #125 revealed he/she was not sure when he/she should apply or remove the device, because he/she was under impression that they were hurting the resident.

Interview with registered staff RPN #109 revealed on July 6, 2017, he/she found a part of the device in the nursing room, and applied it on the resident The PSW staff informed the RPN that the resident removed the device. When the RPN tried to apply again the resident refused the device. The resident performed the everyday activities of living without the device.

The progress notes revealed on an identified date the resident was assessed by a member of the multidisciplinary team because the resident was missing a part of the device.

A review of Kardex and interview with PSW # 125 revealed the written plan of care did not give direction about resident #025's device by whom (PSW or RN) and when to be applied, and where to be kept.

A review of the written plan of care and interview with DOC confirmed that resident #025's written plan of care did not give clear direction to staff in regards to resident's device application and storage. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Record review of a letter of complaint from resident #023 submitted to the MOHLTC by the home revealed resident #023 alleged PSW #152 did not provide personal care to him \her according to his/her specifications on a specified date, and yelled at him/her.

Interview with resident #023 revealed that on an identified date in evening, PSW #152 provided personal care to the resident in a way that he/she felt was wrong. According to the resident when he/she told the PSW he/she was not doing it correctly, it appeared to him/her that PSW #152 started yelling at him/her.

Interview with PSW #152 revealed he/she provided resident #023 with his/her evening personal care on an identified date, in his/her room. The resident liked to have his/her personal care done in a particular manner.. The resident had directed the PSW regarding his/her preferences in how he/she wanted his/her nightly personal care to be done when he/she started caring for the resident during an identified period, and he/she would always do it the way the resident wanted it done. The PSW reported that on an identified date, he/she may have missed a step while providing personal care to resident #023 and he/she became angry with him/her and made rude comments- the PSW did not respond and continued with providing personal care to the resident as per his/her request.

Interview with PSW #153 revealed that he/she was resident #023's regular caregiver on the evening shift and provides him/her with nightly personal care following his/her preferences for the entire process. The resident is very particular in the way in which he

\she wants the personal care to be provided. The resident had directed the PSW regarding his/her preferences in how he/she wanted his/her nightly personal care to be done when he/she started caring for the resident, and he/she would always do it the way the resident wanted it done. The PSW stated that if the resident is not provided the personal care according to his/her specifications, he/she will not be satisfied and become vocal with staff.

Record review of resident #023's written care plan and kardex did not include resident's specific preferences regarding his/her nightly personal care.

Record review of the home's investigation notes, including CI report and interview with PSW #153 revealed that the PSW missed a step during the resident's nightly personal care on an identified date, but did not yell at the resident when he/she became upset with him/her making derogatory remarks towards him/her.

Interview with the DOC confirmed that the resident had very specific preferences regarding his nightly personal care and the care plan and kardex had not been updated to reflect them. [s. 6. (2)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents,the investigation has commenced immediately.

Intake # 010022-17 was inspected because of a complaint submitted to the home by a Substitute Decision maker (SDM) about a lost resident's personal item in the home in 2015 and not getting a response from the home about the outcome.

A review of the home's investigation records revealed on an identified date in 2015, a family member of resident #025 complained to a staff member staff #150 that a personal item was missing from the resident room. Staff #150 communicated about the missing

item with the DOC staff #101, and search was initiated. On a later date, the DOC responded to staff #150 that the personal item was not found. Interview with staff #101 revealed it was expectation that the person who received the complaint to reply to the complainant, whereas staff #150 thought it was the nursing department responsibility to reply to the complainant.

Interview with staff #150 and staff #101 confirmed that the response was not provided within 10 business days of receipt of the complaint because of mis-communication between the management staff in the home. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

Intake #010022-17 was inspected because of a complaint from resident #025's family member for a lost personal item in the home, submitted to the home on an identified date in 2015.

Interview with DOC staff # 101 revealed that all complaints are documented on a Client Service Response (CSR) form and collected in a binder. A review of the 2015 complaints binder and interview with staff #101 and #150 confirmed that the record of resident #025's family member complaint from the identified date in 2015 was not kept in the complaints record. [s. 101. (2)]

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Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 12th day of September, 2017

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

Original report signed by the inspector.