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 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
Dec 24, 2018	2018_754727_0009	025351-17, 028971-17, 003139-18, 010152-18, 013381-18	Complaint

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

Westside
1145 Albion Road ETOBICOKE ON M9V 4J7

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

JOANNA WHITE (727), MATTHEW CHIU (565), PRAVEENA SITTAMPALAM (699)

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): November 26, 27, 28, 29, 30, December 3, 4, 5, 6 and 7, 2018.

During this inspection the following Complaint intakes were inspected: Log #025351-17 related to oxygen use; Log #028971-17 and 003139-18 related to staff to resident abuse; Log #010152-18 related to pest control and housekeeping; Log #013381-18 related to medication error.

This complaint inspection was conducted concurrently with Critical Incident and Follow-up inspections #2018_650565_0019.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Service Manager (MSM), Pharmacy consultant, Housekeeping staff, Physiotherapists, Physiotherapist Assistant (PTA), Residents and Family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint, related to resident #026 who sustained injury of unknown cause.

A review of resident #026's health records revealed the resident had both physical and cognitive impairments. The plan of care revealed the resident was at high risk for falls and required one-person assist for transfer.

Progress notes on specified dates revealed the resident had 13 falls over a three month period. On three of these falls the resident was found sitting on a floor mat in their room.

Observations by inspector #565 on two specific dates revealed that resident #026 had two floor mats, one on each side of the resident's bed, were placed on the floor while resident #026 was in bed.

Further review of resident #026's care plan included falls prevention interventions but did not include the use of floor mats for the resident.

Interviews with PSWs #125, #128, #129, and RPN #126 indicated resident #026 was at high risk for falls and unsteady on their feet. They might attempt to self-transfer getting up from bed, and might fall. The above mentioned staff members stated the use of the floor mats was a way to prevent injuries when the resident falls, and they had been used for a long period of time.

The staff members did not recall the exact date that they implemented the use of floor mats for the resident. PSW #128 and RPN #126 acknowledged that the plan of care did not specify the use of floor mat for the resident.

Interview with the DOC indicated the home had implemented the use of the floor mats for resident #026. The DOC confirmed resident #026's plan of care did not set out the planned care related to the use of floor mats.

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective.

The MOHLTC received a complaint, related to resident #026 who sustained injury of unknown cause.

A review of resident #026's health records revealed the resident had both physical and cognitive impairments. The plan of care revealed the resident was at high risk for falls and required one-person assist for transfer.

Progress notes on specified dates revealed the resident had 13 falls over a three month period. On three of these falls the resident was found sitting on a floor mat in their room.

Further review of resident #026's care plan included falls prevention interventions. The care plan specified a goal that the resident will remain free from falls through next review and was last revised prior to the date of the first fall. The care plan also included several interventions.

Interviews with PSWs #125, #128, #129, and RPN #126 indicated resident #026 was at high risk for falls and unsteady on their feet. They might attempt to self-transfer getting up from bed, and might fall. PSWs #128, #129, and RPN #126 further stated the fall prevention interventions might reduce the number of falls, but PSW #128 and RPN #126 stated they had been ineffective in keeping the resident free from falls. PSW #129 and

RPN #126 reported that resident #026 fell recently. The above mentioned staff members acknowledged they did not recall that the fall prevention interventions were changed during the above mentioned period.

Interview with the DOC indicated the home's fall prevention management program was implemented to prevent the residents' falls and injuries. The DOC confirmed the falls prevention plan of care for resident #026 had not been effective, as the resident continued to fall, and the plan was not revised as required.

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 was a written plan of care for each resident that sets out the planned care for the resident,
- the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with.

The MOHLTC received a complaint related to resident #002 who received an incorrect medication on a specified date.

Resident #002 reported they noticed half of a pill of incorrect medication was dispensed, during the morning medication administration on a specified date. Resident #002 returned the incorrect pill to RN #117, and they became confused upon seeing the pill.

Resident #002's care plan revealed the resident was able to self-administer medications.The resident was cognitively intact and their daily decision making was consistent and reasonable.

The resident's Medication Administration Record (MAR) revealed the medications the resident was to receive.

On a specified date resident #002 approached RN #117 after observing an incorrect pill was dispensed in their medication cup.

A review of the home's Medication Administration Procedure 13-010.01 indicated the following:
-any medication discrepancy will be clarified, and verified with the Physician before administration of the medication;
-administer medication only after the nine rights have been checked (correct resident, medication, route, dose, time, site, reason, frequency, documentation);
-confirm correct drugs through verification on MAR sheet/eMar with each drug in the package.

An interview with the home's pharmacy consultant, acknowledged that the pharmacy's automatic strip packaging machine had packaged an extra half tablet for resident #002 in error.

The consultant further added that the medication package verification process was not followed correctly, resulting in a non-prescribed tablet being packaged for the resident.

An interview with Director of Care (DOC) acknowledged that staff are expected to follow the medication administration procedure when there is a medication discrepancy and contact the pharmacy or physician. The DOC further added that the home's medication

administration procedure was not followed, as the pharmacy confirmed there was an incorrect drug packaged for this resident.

Issued on this 29th day of January, 2019

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

Original report signed by the inspector.