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
Apr 10, 2019	2019_650565_0005	015580-17, 022041-17, 023937-17, 029330-17, 002326-18, 029158-18, 030546-18, 031423-18	Critical Incident System

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

MATTHEW CHIU (565), JULIENNE NGONLOGA (502), NICOLE RANGER (189)

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): March 4, 5, 6, 7, 8, 11, 12, 13, and 14, 2019.

During the course of the inspection, the following Critical Incident System (CIS) intake logs were inspected:
- #015580-17, #022041-17, #029158-18 related prevention of abuse and neglect,
- #023937-17, #030546-18 related to falls prevention, and
- #002326-18, #029330-17, #031423-18 related to resident injury resulting in significant change in health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Nurse Manager (NM), Charge Nurse (CN), Registered Nurse (RN), Registered Practical Nurse (RPN), Physiotherapist (PT), Personal Support Worker (PSW), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 the care set out in the plan of care was provided to the resident as specified in the plan.

Review of a CIS report revealed that on an identified date and time, a PSW reported to RPN #121 that resident #001 had an identified injury. The CIS report further stated the home investigated and did not identify the cause of the injury. During the investigation, the home found out that on the identified shift before the above mentioned date, one PSW didn't follow the resident #001's care plan when transferring the resident.

Review of resident #001's Resident Assessment Instrument Minimum Data Set (RAI-MDS) assessment and the care plan revealed the resident had cognitive and physical impairments. The resident required a specified level of assistance for transfer. The home's investigation records identified that PSW #102 did not follow resident #001's plan of care for transferring the resident.

Interviews with PSWs #102, #104, RPNs #120, and #121 indicated that resident #001 had cognitive and physical impairments and had a specified mode of ambulation. The staff further stated the plan of care for the resident's transfer, prior to the above mentioned injury, directed staff follow the specified level of assistance for transferring resident #001.

PSW #102 further stated that on an identified date and time, they transferred resident #001 using a specified technique instead of the transfer assistance specified in the resident's plan of care. PSW #102 admitted that it was wrong.

In an interview, the ADOC and the ED stated that the above mentioned specified level of assistance should have been used by PSW #102 to transfer resident #001 on the above mentioned date. The staff members acknowledged that when PSW #102 transferred resident #001 without using the specified level of assistance, the care specified in resident #001's transfer plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

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

A CIS report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) related to an incident of fall with injury.

Review of the CIS report indicated that on an identified date and time, resident #015 was observed lying on the floor in their room. The resident stated that they got up from the bed for an intended action, lost their balance, and fell. The next day, the resident was transferred to hospital, and they were diagnosed with a specified significant injury. Resident #015 deceased on an identified date, and the causes of death included complications from the injury.

Review of resident #015's health record indicated that the resident was at an identified risk for falls and cognitive impairment. The progress notes documented the following fall incidents:
- Two identified falls, including the above mentioned incident, in the same month that the resident was found lying in their room.
- Four identified falls indicating that the resident attempted the above mentioned intended action and fell.

From the progress notes reviewed, the resident indicated that they lost their balance while attempting the intended action.

Review of resident #015's plan of care completed after the incidents of fall mentioned above indicated that the plan had specified goals and interventions to reduce the resident's risk for falls.

The inspector reviewed the identified post-fall records and found that the resident's

written plan of care did not identify any intervention to address the risk associated with the reoccurrence of the fall when the resident tried the above mentioned intended action.

In separate interviews, RPN #124, the PT and the ADOC indicated that after a resident had fallen, the staff should complete the identified post-fall records to identify the root cause of the fall and implement interventions to reduce the risk for falls accordingly.

In an interview, the DOC indicated that the root cause for resident #015's falls may include their need to attempt the above mentioned intended action and the use of identified medications. The DOC acknowledged after a review of the plan of care that different approaches were not considered in the revision of the plan of care for resident #015. [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 care set out in the plan of care is provided to the resident as specified in the plan, and
- if the resident is being 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, to be implemented voluntarily.

WN #2: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A CIS report was submitted to the MOHLTC related to an incident of fall with injury.

Review of the CIS report indicated that on an identified date and time, resident #015 was observed lying on the floor in their room. The resident stated that they got up from the bed for an intended action, lost their balance, and fell.

Review of the progress notes indicated that resident #015 had sustained specified injuries on assessment. Further review of the progress notes indicated that resident #015 was transferred back to bed by an identified number of staff.

The progress notes further stated that on the next day, the resident was transferred to hospital, and they were diagnosed with a specified significant injury. Resident #015 deceased on an identified date, and the causes of death included complications from the injury.

Review of the home's investigation notes indicated that several identified staff members violated the home's policy by not assessing resident #015 properly and transferring them after the fall without using a mechanical lift.

Review of the Assisting a Resident/Client form indicated if the resident/client is physically unable to assist themselves to a crawl or all four position, a mechanical lift must be used or a call to the ambulance for assistance.

PSW #125 indicated that they transferred resident #015 back to bed under the direction of the RPN #124. They acknowledged that they should have transferred the resident with the specified mechanical lift as the resident was not able to transfer back to bed independently.

RPN #124 indicated that after the fall, they assessed resident #015 and transferred them back to bed with the help of two PSWs. The RPN indicated that the expectation was to use the specified mechanical lift to move the resident from the floor after a fall.

In separate interviews, PSWs #125, #128, RPN #124, the PT and ADOC indicated that if the resident could not get up independently after a fall, staff should use a mechanical lift to transfer the resident to bed or chair. The ADOC acknowledged that the identified staff did not use safe transfer techniques when assisting resident #015 after the above mentioned fall.

In an interview, the DOC indicated that when a resident had fallen, staff are expected to

transfer the resident back to bed or chair using a mechanical lift unless the resident is able to go on their knees or their hands independently. The DOC indicated that staff should not rely on weight bearing status in the plan of care as the status of the resident can change after the fall. [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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who requires continence care products had sufficient changes to remain clean, dry and comfortable.

On an identified date, the home submitted a CIS report related to an allegation of neglect of a resident. The CIS report stated on an identified date and time, resident #016 called PSW #110 on duty to change their incontinent product. According to the resident, PSW #110 gave them specified directions instead of changing their incontinent product.

Interview with resident #016 indicated that during the above mentioned date and time, they required assistance to change their incontinent product. Resident #016 reported that PSW #110 came into their room and gave them specified directions instead of changing their incontinent product.

Interview with PSW #100 revealed that on the identified date when they were starting their shift, they found resident #016 upset. PSW #100 reported that the resident informed them that PSW #110 did not assist them to be changed, but provided them with the specified directions. PSW #100 reported that they found identified signs indicating that the resident was not clean and dry. PSW #100 reported that they informed RN #112 about the incident.

A review of the home's investigation revealed on the identified date, resident #016 told RN #112 that they called the PSW at an identified time to be changed. The PSW instructed resident #016 with specified directions instead of changing them. RN #112 reported that they observed the identified signs indicating resident #016 was not clean and dry. The home's investigation records further determined that PSW #110 did not provide the continence care to resident #016 as required.

Interview with PSW #110 indicated they did not recall what happened.

Interview with the DOC revealed that an investigation was conducted and acknowledged that resident #016 did not receive assistance to remain clean, dry and comfortable. [s. 51. (2) (g)]

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 residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity was fully respected and promoted.

On an identified date, the home submitted a CIS report related to an allegation of neglect of a resident. The CIS report stated on an identified date and time, resident #016 called PSW #110 on duty to change their incontinent product. According to the resident, PSW #110 gave them specified directions instead of changing their incontinent product.

Interview with resident #016 indicated that during the above mentioned date and time, they required assistance to change their incontinent product. Resident #016 reported that PSW #110 came into their room and gave them specified directions instead of changing their incontinent product. Resident #016 reported that following the specified directions instead of getting assistance with changing their incontinent product made them feel "different".

Interview with PSW #100 revealed that on the identified date when they were starting their shift, they found resident #016 upset. PSW #100 reported that the resident informed them that PSW #110 did not assist them to be changed, but provided them with the specified directions. PSW #100 reported that they found identified signs indicating that the resident was not clean and dry.

Interview with the DOC acknowledged that giving resident #016 the specified directions instead of assistance with an incontinent product was inappropriate and that the resident's dignity was not respected. [s. 3. (1) 1.]

Issued on this 25th day of April, 2019

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

Original report signed by the inspector.