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
Division de la responsabilisation et de la performance du système de santé
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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
Dec 29, 30, 2011; Jan 3, 4, 5, 6, Apr 23, 24, 2012	2011_104196_0017	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

PINEWOOD COURT
2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5

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

LAUREN TENHUNEN (196)

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 Administrator, the Director of Care(DOC), Registered Nurses(RN), Registered Practical Nurses(RPN), RAI Coordinator, Staff Educator, Physiotherapist, Physiotherapy Aid, Personal Support Workers(PSW), Residents and family members

During the course of the inspection, the inspector(s) conducted a tour of the home, observed the provision of care and services to residents of the home, reviewed the health care records of several residents, the Critical Incident reports submitted to the Ministry of Health and Long-Term Care(MOHLTC), fall prevention and management program, various home policies and procedures

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care
Specifically failed to comply with the following subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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. A resident was admitted to the home in October 2011 and had a fall with injury requiring transfer to hospital. The resident was discharged back to the home and then experienced another fall requiring transfer back to the hospital for a second time. The inspector reviewed the "Resident Admission Assessment/Plan of Care" document for revisions to the resident's plan of care after the first fall. No revisions were noted on this document under the category of "safety" and there were no strategies or fall prevention interventions identified. The online care plan was not initiated until later in October 2011, after the second fall with injury.
The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007,S.O.2007, c. 8, s. 6 (10)(b).]
2. A Critical Incident was submitted to the MOHLTC for an incident in November 2011 where a resident left unaccompanied for a walk outside the home and had become lost out in the community. A second incident occurred in December 2011 and a Critical Incident report was submitted when this resident became disoriented and lost, requiring assistance back to the home. It was identified that this resident had a form of dementia which resulted in impaired cognition. The plan of care for this resident was reviewed by the inspector and it was determined that they had not been reassessed and the plan of care revised until after the second incident in December 2011.
The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007,S.O.2007, c. 8, s. 6 (10)(b).]
3. Inspector reviewed the online and hard copy of the care plan for a resident. Listed under the focus of falls, the care plan outlined the use of "an Orion tilt chair as a PASD". An interview was conducted with a Registered staff member on December 30, 2011. This staff member stated that this resident "used the tilt chair before" and now "uses a regular wheelchair, no restraint, one person transfer and uses the wheelchair and propels themself if they are weak". The resident's care plan was not updated to indicate that the Orion tilt chair was no longer in use.
The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007,S.O.2007, c. 8, s. 6 (10)(b).]
4. An interview was conducted with a staff member on January 4, 2012. The staff member stated that a resident uses a bed alarm as a fall prevention strategy. Inspector reviewed the written care plan that was in place on December 30, 2011 for this resident and it did not contain reference to the use of a bed alarm.
The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007, S.O.2007,c. 8, s. 6 (1).(c)]
5. A resident had a fall with injury in September 2011 which resulted in transfer to hospital. An interview was conducted with a Registered staff member on December 30, 2011. This staff member confirmed that there were "no changes to the resident's care plan since the fall with injury in September 2011" and that the resident is currently using a bed alarm and a high/low bed although these are not identified in the care plan. An interview was conducted with a staff member on January 4, 2012 regarding their care plan entry that identified a resident as a "medium risk" for falls dated Apr. 27, 2011. This staff member stated that this resident is now at a "high" risk for falls as a result of a falls assessment that was done in September 2011 and the care plan was not updated since this reassessment and "staff should have updated or revised the care plan as changes occur".
The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007,S.O.2007, c. 8, s. 6 (10).(b)]
6. On January 3, 2012 at 1345hrs, the inspector observed a resident laying awake in their bed with both mobility rails elevated, the bed not in its lowest position, the bed alarm monitor on bedside table with red light on over the "hold" button and the floor mat up against the wall. The inspector spoke with a staff member and they stated that they were now taking care of this resident for the remainder of the day shift. The inspector asked the staff member about the fall prevention measures that were in place for this resident and they identified the use of the bed alarm and the bed is to be in the lowest position. The staff member came into the resident's room, upon the inspector's request and confirmed that the bed was not in the lowest position, and noted the floor mat was up against the wall and not on the floor beside the bed. The staff member then assisted the resident to a standing position at the side of the bed and the bed alarm did not sound and it was identified that the bed alarm was not activated.
The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007,c. 8, s. 6 (7).]
7. A resident had three documented falls in October 2011. A fall also occurred late in October 2011 and the resident

was subsequently diagnosed with a fracture. The inspector reviewed this resident's care plan online for fall prevention strategies and it was identified that this resident was not reassessed and the plan of care not reviewed or revised to include strategies, despite these falls in the month of October 2011.
The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [LTCHA 2007,S.O.2007, c. 8, s. 6 (10)(b).]
8. On December 30, 2011 at 1540hrs, the inspector reviewed the care plan binder at the nursing desk for the care plan for a resident. The care plan was not located in the binder under the resident's room number and a Registered staff member was questioned but was unsure where it had gone. The care plan was available online for viewing, but PSWs did not have access to the computers.
The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [LTCHA 2007, S.O.2007,c. 8, s. 6 (8).]
9. An interview was conducted with a PSW on January 3, 2012 They stated that they "would look in the flowsheet binders and refer to the kardex for information about a resident" and "if they had time they would look at the care plans". An interview was conducted with a Registered staff member on January 3, 2012. They stated that this resident uses a bed alarm while in bed and also a chair alarm when up in her wheelchair. Inspector reviewed the kardex for this resident, dated September 6, 2011, and it identified them as being "independent for walking in room with no setup or physical help from staff, supervision with walking in corridor" and did not contain any information regarding the resident's fall risk or the use of bed alarm or a chair alarm. A PSW stated on Jan. 3, 2012 that this resident needs assistance with walking as they are unsteady on their feet. The resident's written plan of care did not set out clear directions to staff and others who provide direct care.
The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [LTCHA 2007,S.O.2007, c. 8, s. 6 (1)(c).]

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 that will ensure that all residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, that will ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, that will ensure that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it and to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan
Specifically failed to comply with the following subsections:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. A resident had a fall with injury that required transfer to hospital within the first 24 hours of admission to the home.
2. Inspector reviewed the admission progress notes for this resident and it was noted that they required supervised transfers.
3. The "Resident Admission Assessment/Plan of Care" that was initiated on the date of this resident's admission in October 2011 was reviewed by the inspector. This plan of care identified that the resident had a history of falls and that a "Falls Risk Assessment" was completed but it did not contain any any interventions or strategies for fall prevention.
4. The "Falls Risk Assessment" from the date of admission was reviewed and it scored the resident as "14.0 - High risk" for falls.

The licensee failed to ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. [O. Reg. 79/10, s. 24 (4).]

WN #3: 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. (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. Inspector reviewed the "Resident Admission Assessment/Plan of Care" dated October 12, 2011 for information regarding a resident's responsive behaviours. The sections titled "Cognitive Patterns, Mood and Behaviour, Activity Pursuits Patterns and Safety" did not contain any information and these areas on this initial plan of care are blank. According to a Registered staff member, this plan of care is the initial plan and then the care plan is started online with applicable foci.
2. Inspector reviewed the online care plan dated October 17, 2011 that was in effect at the time of the resident's incidents of leaving the home, unaccompanied and becoming lost in the community. The care plan did not include reference to responsive behaviours and did not contain interventions for any behaviours that the resident may exhibit.

The licensee failed to 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; [O.Reg.79/10,s.53(4)(a)(b).]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents
Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. Inspector reviewed the Critical Incident report submitted to the MOHLTC in September 2011 for an alleged incident of verbal and physical abuse toward two residents by a Registered staff member. It was noted that the substitute decision maker(SDM) for both of these residents were not notified of the alleged abuse when the home became aware of the incident.
2. An interview was conducted with the Administrator of the home on January 4, 2012 and they stated the home had completed their investigation of this incident and had determined that the abuse had not occurred and therefore the SDM was not notified.

The licensee failed to ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, (a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and (b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. [O. Reg. 79/10, s. 97 (1).]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. A resident had a fall with injury that required transfer to hospital in October 2011.
2. A Critical Incident report was submitted to the Director on October 19, 2011.
3. The Administrator of the home, was interviewed by the inspector on January 4, 2012 and stated that "the report was completed and saved but in error was not submitted until October 19, 2011". The report was not received within within the required time frame.

The licensee failed to ensure that the Director is informed of an incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection(4): 4. An injury in respect of which a person is taken to hospital.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. Inspector observed on December 29, 2011 a Registered staff member exit the medication room with a tray containing three medication cups with spoons in them and a few cups of liquid. The staff member was observed to administer a pill from paper medication cup to a resident. The medication cup was unlabeled, without a resident name or a medication name. Two other residents were administered medications off of this same tray, out of unlabelled medication cups. The staff member stated that they usually write the resident's name on the spoon that is in the med cup, but did not do this this time.
2. Inspector reviewed a copy of the home's policy for medication administration #LTC-G-05-ON/BC with a revision date of January 2011. The policy states there is no pre-pouring of medication, the medication cart is used during medication pass and that medications are administered only after the nine "rights" have been checked by the Registered staff in accordance with provincial recommendations.
3. The DOC was interviewed by the inspector on December 29, 2011 and confirmed that administering medications from a tray with unlabeled med cups is not following the home's policy for medication administration. They also stated "staff are to follow the best practice guidelines of the College of Nurses of Ontario for medications".

The licensee failed to ensure their written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and , if there are none, in acordance with prevailing practices; [O.Reg.79/10,s.114(3)(a).]

Issued on this 25th day of April, 2012

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

#196.