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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2017	2017_621547_0009	008226-17	Resident Quality Inspection

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

MONTFORT
705 Montreal Road OTTAWA ON K1K 0M9

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

LISA KLUKE (547), JOANNE HENRIE (550), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 4-5-6-7-10-11-12-13-14, 2017

The following critical incident inspections were conducted concurrently during this inspection:
Log #003609-17 and Log #011241-17 related to resident falls,
Log #005439-17 and Log #005965-17 related to allegations of suspected resident to resident abuse

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the home's Resident Assessment Instrument (RAI) Coordinators, Housekeeping attendants, Environmental Services staff, Dietary aides, the Administrative Assistant, the Clinician, the Education Manager, the Environmental Services Manager, Activity and Volunteer Coordinator, Resident and Family services Coordinator, the Registered Dietitian, a Geriatric Psychiatry Outreach nurse, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the General Director of the home (Administrator).

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures, staff work routines, posted menus, observed resident rooms, resident common areas, the Admission process and Quality Improvement system, Residents' Council and Family Council minutes, medication administration passes, meal services, the delivery of resident care and services and staff to resident /resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 LTCHA, 2007, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care regarding grooming is provided to resident #012 as specified in the plan.

On July 4, 2017, during an interview with resident #012's family, they indicated to inspector #550 that they visit often at various times in the day and that often they will find that the resident was not groomed properly. Staff will tell the family that the resident refused care but feels that the staff do not groom the resident as they know that the family will do it when they visit. The family further indicated that the resident never refuses this specified grooming when they do it.

The resident was observed by Inspector #550 on July 4, 10 and 11, at various times during the day not properly groomed.

Resident #012's current plan of care was reviewed by the inspector. It was documented this resident required this specified grooming under personal hygiene and grooming daily.

On July 11, 2017 at 1230 hours, the inspector interviewed PSW #124 who was the PSW caring for the resident that day. She indicated to the inspector that resident #012 is dependent of staff for this specified grooming need and that the resident sometimes required the assistance of two staff as the resident often refused care. When the resident refused to this specified grooming, the PSW was to inform the nurse and document this refusal in point of care. PSW #124 further indicated she groomed the resident that morning. When the inspector indicated that the resident's grooming was worse than it was the day before on observation, she then indicated to the inspector that she was not able to groom the resident that morning as the care was refused. She did not document this refusal or inform the nurse as required, and this specified grooming was not provided to the resident. [s. 6. (7)]

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 care set out in resident #012's plan of care related to grooming is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's furnishings and equipment are kept clean and sanitary.

On July 04, 2017, Inspectors #592 observed that the furniture in the " Val Des Roses" dining room was soiled. Inspector #592 observed a total of 10 dining tables with an accumulation of dry food debris and white streaks on each table leg. Two feeding black stools were also observed with white dry streaks on the frames.

It is to be noted that the home has a total of four unit's which all have dining rooms for a total of four dining rooms.

On July 6, 2017 Inspector #592 inspected the furniture in the " Pommeraie" and "Pineraie" dining rooms. A total of nine dining tables were observed in the "Pommeraie" dining room with accumulation of dry food debris and white streaks on each table leg.

Two black feeding stools were also observed with grey streaks on the frames. A total of 10 tables were observed in the "Pineraie" dining room with accumulation of dry food debris and white streaks on each table leg. Three black feeding stools were also observed with grey streaks on the frames.

On July 06, 2017, during an interview with the environmental services staff #106, he indicated to Inspector #592 that part of his responsibilities was doing the home's repairs such as painting and fixing fixtures, as well as the cleaning of each dining room. He further indicated that the floor in each dining room was cleaned, including the tables, the table legs, the resident's chairs and staff feeding stools which was done three times a day after each meal.

On July 06, 2017, during an interview with the Environmental Services Manager, he indicated to Inspector #592 that the staff responsible for the dining rooms were titled "heavy duty cleaner" and that the routine was to do a "spot mop check" after breakfast and lunch. He further indicated that the staff were instructed to remove most of the dirt, however a deep clean of the dining rooms was done each evening. When Inspector #592 inquired about the table legs and the black feeding stools, he indicated that the table legs were to be cleaned every two weeks and as needed and that the feeding stools were to be cleaned every day. Inspector #592 accompanied by the Environmental Services Manager to observe the tables in the dining room on "Pommeraie unit". The Environmental Services Manager indicated to the Inspector that the table legs and feeding stools were dirty and that he was unsure if the table legs were on the staff assignments to be cleaned.

On July 07, 2017, the Environmental Services Manager indicated to Inspector #592 that he noted that the table legs were not assigned to his staff members, therefore he was doing a follow-up with other departments to ensure that the furniture in the dining room would be kept clean and sanitary. [s. 15. (2) (a)]

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 home's furnishings and equipment used by residents are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:

1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.
3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.

5. Misuse or misappropriation of funding provided to a licensee under the Act.

Neglect is defined as per O.Reg.79/10. s.5 to mean the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Physical abuse is defined as per O.Reg.79/10.s.2(1)c. to mean the use of physical force by a resident that causes physical injury to another resident.

1. On July 5, 2017 resident #022 reported to Inspector #547 during an interview that RPN #129 ignored the residents request for assistance to manage pain on a specified date. Resident #022 indicated to have been in the middle of specified procedures and was sore.The resident went to the nursing station during the night, and called out to the nurse from the hallway, but no response. The resident entered the nursing station and noticed that RPN #129 was seated in front of the computer and did not respond to the resident's call. The resident indicated that she looked at the resident asking what was required, the resident indicated that a specified body area was very uncomfortable and RPN #129 asked the resident to go self administer a specified treatment. Resident #022 was upset that RPN #129 never left the computer area or offered any assistance for the resident's pain that kept the resident awake most of the night. The resident reported the incident the next morning to the Director of Care and she indicated that she would follow-up.

Resident #022's health care records indicated that the resident was admitted to the home on a specified date in 2013 with several medical diagnoses. Resident #022 is alert and oriented and able to direct the resident's own care needs. Resident #022's progress notes documented that the resident reported pain to this specified area later in the same day to another nurse and required a specified analgesic for pain relief. Resident had family take the resident to the a specified specialist to assess pain and arrange for a specified procedure to releive pain.

The Director of Care provided the resident's complaint documentation and investigation report related to this incident of that specified date. The investigation notes indicated that RPN #129 denied this incident having occurred indicating that she had no recall to this incident. The Director of Care verified the camera video of the unit for the early morning hours of this specified date as the resident indicated in this complaint, and the resident did go to the nursing station at a specified time, then entered the nursing station for about 1.5 minutes and then returned to the resident's room. RPN #129 was observed to not

have left the nursing station until a specified time, 40 minutes later. No record of any analgesic provided to the resident during this shift. The Director of Care's investigation report indicated she informed RPN #129 that she had seen the video replay of this unit and noted that the resident had come to the nursing station as indicated in this complaint. RPN #129 indicated that she had no recall of this incident. RPN #129 was asked by the DOC to apologize to resident #022 as this incident was captured on the camera video on the unit.

The Director of Care indicated to Inspector #547 that she did not report the incident as she managed this as a complaint. The DOC indicated that at that time, did not think of it as abuse of a resident by anyone or neglect of a resident by the licensee or staff and therefore she did not report this incident to the Director of the Ministry of Health and Long Term Care as required by this section. [s. 24. (1)]

2. A specified critical incident was submitted to the Director reporting an incident of alleged resident to resident physical abuse. It was reported that resident #005 was hit on a specified body area by resident #050 which caused a small laceration to a specified location on this body area for resident #005. The incident occurred on a specified date and time and it was reported to the Director the only the next day.

As per the documentation in the progress notes, RPN #128 immediately informed the Director of Care of the incident as required. During an interview, the DOC indicated to inspector #592 that she did not report the incident immediately as she was not at the Long-Term Care home at the time of the incident and she did not have the after hour pager number with her to report the incident as required. She reported the incident the next day by submitting a critical incident. [s. 24. (1)]

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 person who had reasonable grounds to suspect that neglect of a resident by staff that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by the residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour on July 04, 2017, Inspector #592 observed unlocked and unsupervised storage rooms on the Pommeraie unit on the second floor and on the Tulipe unit on the first floor titled " Chariot des soins". These storage rooms contained one linen cart and one hamper bag with soiled linen in each. The inspector noticed that the storage rooms were accessible to the unsupervised residents walking in those resident care hallways and this room was not supervised by staff. A posted memo with a stop sign was noted on the doors indicating " garder portes fermees et verrouillees en tout temps svp."

On July 07 and 10, 2017, Inspector #592 observed the same unlocked and unsupervised storage room on the Pommeraie unit on the second floor titled "Chariot des soins". The storage room contained one linen cart and one hamper bag with soiled linen. The inspector noticed that the storage room door was not locked and this room was accessible to the unsupervised residents walking in the area that was not supervised by staff.

On July 10, 2017, in an interview with the DOC, she indicated to Inspector #592 that the above storage room doors should be kept closed and locked at all times as they were non-residential areas. [s. 9. (1) 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 all doors leading to non-residential areas, equipped with locks to restrict unsupervised access to those areas by residents, shall be closed and locked when they are unsupervised by staff in the home, to be implemented voluntarily.

Issued on this 20th day of July, 2017

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

Original report signed by the inspector.