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 # / Registre no	Type of Inspection / Genre d'inspection
May 3, 2017	2017_262630_0009	005969-17	Resident Quality Inspection

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

COLUMBIA FOREST
650 MOUNTAIN MAPLE AVENUE WATERLOO ON N2V 2P7

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

AMIE GIBBS-WARD (630), MELANIE NORTHEY (563), NEIL KIKUTA (658)

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): April 4, 5, 6, 7, 10, 11, 12 and 13, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):

Complaint Log #006172-17related to pain management;

**Critical Incident Log #007580-16/CI 2856-000006-16 related to alleged abuse;
Critical Incident Log #010766-16/CI 2856-000008-16 related to a fall with injury;
Critical Incident Log #015251-16/CI 2856-000009-16 related to alleged improper care;
Critical Incident Log #015307-16/CI 2856-000010-16 related to alleged abuse;
Critical Incident Log #016340-16/CI 2856-000012-16 related to related to an attempted suicide;
Critical Incident Log #020346-16/CI 2856-000014-16 related to alleged abuse;
Critical Incident Log #024052-16/CI 2856-000015-16 related to alleged abuse;
Critical Incident Log #026754-16/CI 2856-000016-16 related to alleged abuse;
Critical Incident Log #028714-16/CI 2856-000019-16 related to alleged abuse;
Critical Incident Log #032058-16/CI 2856-000021-16 related to alleged abuse;
Critical Incident Log #002892-17/CI 2856-000002-17 related to alleged abuse;
Critical Incident Log #003970-17/CI 2856-000004-17 related to alleged abuse.**

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, five Team Leads, the Social Worker (SW), the Physiotherapist (PT) , four Registered Nurses (RN), six Registered Practical Nurses (RPN), sixteen Personal Support Workers (PSWs), one Dietary Aide, five family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed dining service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed various meeting minutes.

Inspector #218 (April Tolentino) was also present during this inspection.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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	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:

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 the written plan of care provided clear direction to staff and others who provided direct care to the resident.

Multiple observations during the inspection found an identified resident was using specific devices.

During interviews with multiple staff it was reported that this identified resident used specific devices for the purpose of comfort and positioning. Staff reported they would refer to the plan of care, Kardex and the Point of Care (POC) for direction regarding a resident's use of these specific devices.

The clinical record for this identified resident showed that the electronic plan of care, Kardex and POC provided no direction for staff regarding these specified devices.

During an interview with a Team Lead it was reported that it was the expectation in the home that the plan of care would provide clear direction for staff regarding the use these specific devices. This Team Lead acknowledged that the plan of care did not to provide clear direction for staff regarding these devices for this identified resident.

The severity was determined to be a level two as there was minimal harm or potential for

actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 3, 2015, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_271532_0005. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident’s care needs changed or care set out in the plan of care was no longer necessary.

A. Review of an identified resident’s plan of care stated that the resident required extensive assistance with two staff for personal care. This plan of care also indicated that this resident was in a specific program within the home related to the provision of personal care.

During interviews with multiple staff members it was reported that this identified resident required one person extensive assistance for all care. A staff member acknowledged that the plan of care for this resident did not match the level of care required by the resident. The staff member also said that they did not believe this identified resident needed to be in the specified program.

During an interview with the Director of Care (DOC) it was stated that it was the expectation in the home that the plan of care would be updated at a minimum on a quarterly basis, but also when the plan of care changed. (658)

B. During interviews with multiple staff members it was reported that an identified resident experienced a decline in continence and had a change in their care needs. Staff said they would look in the plan of care, Kardex and POC to know what care the resident required for toileting and continence care.

A review of this identified resident's clinical record showed that the plan of care for continence did not reflect the most recent Resident Assessment Instrument Minimum Data Set (RAI MDS) assessment, did not match the level of incontinence identified through staff documentation in Point of Care (POC) and did not match the “Continence Management Program” List.

During an interview with a Team Lead it was reported that it was the expectation in the home that the plan of care for residents would be based on an assessment or

reassessment of the resident's continence and toileting needs and would reflect any changes in care the resident required. Inspector #630 reviewed the plan of care for this identified resident with this Team Lead and they acknowledged that this was not revised based on an assessment when the resident's continence care needs changed.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on February 3, 2015 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2015_271532_0005. [s. 6. (10) (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 by ensuring that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, that each resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 had occurred immediately reported the suspicion and the information upon which it was 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; 2. Abuse of a resident by the licensee or staff that resulted in harm or risk of harm.

A Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which was identified as "improper/incompetent treatment of a resident that resulted in harm or risk to a resident". This report was submitted to the MOHLTC approximately 18 hours after the incident occurred.

The home's documentation for the investigation of this incident showed that former Associate Director Of Care (ADOC) was informed by the home's Social Worker (SW) that an identified resident had reported a concern with how they had been treated by a staff member. This documentation also showed that former ADOC interviewed the identified resident approximately 14 hours prior to submitting the CIS report to the MOHLTC.

During an interview the Executive Director (ED) reviewed the home's documentation regarding this incident with Inspector #630. The ED said that they started working in the home after this incident occurred and that based on the documentation the Director was not notified immediately of the alleged abuse. The ED said it was the expectation in the

home that the Director would be notified immediately of any incident of alleged abuse or neglect in the home through the CIS including use of the after-hours telephone number if necessary. (630)

2. A Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which was identified an allegation of staff to resident neglect. This report was submitted to the MOHLTC approximately seven days after the incident occurred.

During an interview the Executive Director (ED) they said it was the expectation in the home that the Director would be notified immediately of any incident of alleged abuse or neglect in the home through the CIS including use of the after-hours telephone number if necessary. The licensee failed to ensure that the suspicion of neglect and improper care and the information upon which it was based was immediately reported to the Director. (563)

3. A Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which was identified improper/incompetent treatment of a resident that resulted in harm or risk to a resident. This report was submitted to the MOHLTC approximately seven days after the incident occurred.

During an interview the ED stated that it was the expectation that all improper/incompetent treatment would be immediately reported to the Director. (658)

4. A Critical Incident System (CIS) Report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which was identified as "improper/incompetent treatment of a resident that resulted in harm or risk to a resident". This report was submitted to the MOHLTC approximately six days after the incident occurred.

During an interview the Executive Director (ED) reviewed the home's documentation regarding this incident with Inspector #630. The ED said that they started working in the home after this incident occurred and that based on the documentation the Director was not notified immediately of the alleged abuse. The ED said it was the expectation in the home that the Director would be notified immediately of any incident of alleged abuse or neglect in the home through the CIS including use of the after-hours telephone number if necessary. (630)

5. A Critical Incident System (CIS) Report was submitted to the Ministry of Health and

Long Term Care (MOHLTC) which was identified as alleged abuse/neglect of a resident by a staff member. This report was submitted to the MOHLTC approximately two days after the incident occurred.

During an interview the Executive Director (ED) reviewed the home's documentation regarding this incident with Inspector #630. The ED said that they started working in the home after this incident occurred and that based on the documentation the Director was not notified immediately of the alleged abuse. The ED said it was the expectation in the home that the Director would be notified immediately of any incident of alleged abuse or neglect in the home through the CIS including use of the after-hours telephone number if necessary.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was a pattern during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 30, 2017, as a Written Notification in a Critical Incident Inspection #2017_600568_0003. [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 by ensuring 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: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and that a written record was kept of everything provided for in clauses (a) and (b).

During an interview the Director of Care (DOC) stated that the quarterly review of all medication incidents and adverse drug reactions occurred during the multidisciplinary Medical Advisory Committee (MAC) meetings.

Review of the MAC minutes showed that there were three medication errors in the past quarter prior to the inspection, all were omissions, and that there was ongoing review of incidents.

The DOC acknowledged that there were in fact five medication incidents that occurred during the last quarter and the MAC minutes did not capture this accurately. The DOC stated that medication incidents should be reviewed during the MAC meetings to determine corrective action and strategies to prevent or reduce medication incidents, and acknowledged that no improvements were identified during the most recent quarterly review.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (3)]

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 by ensuring quarterly reviews are undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review were implemented, and that a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The following is further evidence to support Compliance Order #001 issued March 30, 2017, in Critical Incident System inspection # 2017_600568_0003 with a compliance date of May 1, 2017.

The licensee failed to ensure that all residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

For the purposes of the Act and this Regulation, “neglect” means 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.

Record review of a Critical Incident (CIS) Report submitted to the Ministry of Health and Long Term Care (MOHLTC) stated there was an allegation of staff to resident neglect. The CIS Report stated that an identified resident had not received the required personal

care during a specific shift.

The home's investigation notes stated that an identified resident had been found by staff to have not received the personal care they had required. The investigation notes also showed that a specific staff member had documented that care had been completed for this identified resident for care that was not provided.

During an interview with a staff member of the home it was reported that this identified resident had not received the personal care they had required on a specific shift.

Record review of the Resident Non-Abuse Program policy ADMIN1-P10-ENT with an effective date of August 31, 2016, stated, "Revera was committed to providing a safe and supportive environment in which all residents/clients were treated with dignity and respect. All employees must protect the rights of each and every resident entrusted to their care."

The licensee has failed to ensure that this identified resident was protected from neglect as they were not provided personal care and was left in bed without monitoring and was not checked by the staff routinely throughout the specific shift.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 30, 2017, in Critical Incident System Inspection #2017_600568_0003 with a compliance date of May 1, 2017, and on July 9, 2014, in a Critical Incident System Inspection #2014_271532_0025. [s. 19. (1)]

Issued on this 10th day of May, 2017

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

Original report signed by the inspector.