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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Dec 17, 2015	2015_322156_0020	030923-15	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

DOVER CLIFFS
501 St George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

CAROL POLCZ (156), LESLEY EDWARDS (506), LISA VINK (168)

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): November 10, 12, 16, 17, 18, 19, 23, 24, 25, 2015

Critical Incident #028836-15 and Complaints #008175-15, #029584-15 and #029699-15 were conducted simultaneously with this inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Food Services Manager (FSM), Environmental Director (ED), RAI Coordinator, registered nursing staff, personal support workers (PSW's), dietary aides, cooks, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

9 WN(s)
5 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 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home "Pharmacy Policy Section 14: Documentation and Reporting 14:0 Medication Administration Record (MAR) and Treatment Administration Record (TAR)" indicated that "once the resident's medication administration is complete, click on save, and proceed to the next resident". In October, 2015 registered staff #104 poured the medications of residents #013 and #040 at the same time resulting in a medication error. Interview on November 17, 2015 with registered staff #103 and #104 confirmed that the medications should not have been poured at the same time and that staff were to complete the administration of medications to one resident before proceeding to the next. The licensee failed to ensure that the policy was complied with. [s. 8. (1) (b)]

2. B) The home policy LTC-E-60 "Long Term Care Services Manual, Fall Interventions Risk Management Program", last revised March 2014 indicated that when a resident falls the registered staff would complete a clinical assessment and this will be documented, including vital signs every shift for a minimum of 72 hours.

i. Review of resident #019's clinical record indicated that the resident sustained a fall in October, 2015, the clinical assessment was not documented as being complete on both the following consecutive day shifts in October, 2015.
ii. Review of resident #019's clinical record indicated that the resident sustained a fall in November, 2015, the clinical assessment was not documented as being completed on the following evening shift in November and the following night shift in November, 2015.
iii. Review of resident #015's clinical record that the resident sustained a fall in November, 2015. The clinical assessment was not documented as being completed on the night shift of the same date in November, 2015 and the day and night shifts two days later in November, 2015.
This was confirmed through record review and interview with the DOC and Administrator who confirmed that the home's fall intervention risk management program was not complied with. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home's procedure Resident Non-Abuse (Ontario), LP-B-20-ON, revised date September 2011, identified the following:
1. "Any employee or person who becomes aware of, and//or has reasonable grounds to believe, an alleged, suspected or witnessed Resident incident of abuse or neglect will report it immediately to the Executive Director (ED) or, if unavailable, to the most senior Supervisor on shift at the time. The person reporting the suspected abuse will follow the home's reporting requirements to ensure the information is provided to the Executive Director immediately" and
4. "Mandatory reporting under the LTCHA (Ontario): Section 24(1) of the LTCHA requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. It is an offence under the LTCHA to discourage or suppress a mandatory report. The on-line Mandatory Critical Incident System (MCIS) may be used to forward the required request."

According to the progress notes, resident #21 was involved in an interaction with a co-resident in October, 2014. The incident as detailed in the progress notes suggested that there was reasonable grounds to suspect abuse to the co-resident. Interview with registered staff #105 identified that they did not recall any actions taken related to the incident, other than those documented in the clinical record. Discussion with the ED identified that she was unaware of the identified incident, until several weeks later as it was not reported and confirmed that the incident was not reported to the Director as required. The home's procedure was not complied with. [s. 20. (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 written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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. The licensee failed to ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

Resident #021 had a known history of responsive behaviours directed toward staff, as confirmed during interviews with multiple front line staff.
Interview with PSW #110 identified that on an identified date in November, 2015, the resident demonstrated a specific physical responsive behaviours towards them. The staff confirmed that she did not document this specific incident, the interventions nor the resident's response. A review of the progress notes identified that the resident demonstrated verbal responsive behaviours; however, there was no mention of the physical behaviours displayed.
Interview with PSW #106 identified that when she last bathed the resident they demonstrated a specific physical responsive behaviours towards them. A review of the clinical record did not include any documentation regarding this specific incident, the interventions nor the residents response.
Interview with the ED confirmed that the staff did not document the incidents nor complete an incident report as required following a review of the clinical record. Multiple staff interviewed identified that the behaviours demonstrated by the resident recently had increased in both intensity and frequency. A review of recent entries in the clinical record included an increase in the use of an as needed benzodiazepine; however, the document did not consistently include the specific behaviours nor the frequency they were displayed. [s. 53. (4) (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 to ensure that the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the programs included a weight monitoring system to measure and record with respect to each resident i) weight on admission and monthly thereafter and ii) height upon admission and annually thereafter.

i) Resident #045 did not have a weight taken or recorded for the month of May 2015; resident #046 did not have a weight take or recorded for the months of December 2014, January, April or May 2015 and resident #047 did not have weight taken or recorded for the months of December 2014, January, February and October 2015. On November 19, 2015, registered staff #103 confirmed that all residents did not have their weights measured or recorded on a monthly basis.

ii) Resident #041 last had their height measured in November, 2013; resident #042 last had their height measured in October 2011 and resident #043 last had their height measured in December 2013. On November 19, 2015, registered staff #103 confirmed that the home did not ensure that all residents had their height measured and recorded on an annual basis. [s. 68. (2) (e)]

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 programs included a weight monitoring system to measure and record with respect to each resident i) weight on admission and monthly thereafter and ii) height upon admission and annually thereafter, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

On an identified date in October, 2015 resident #013 was administered the medications of resident #040 in error. The home monitored the resident and there were no ill effects. This was confirmed with registered staff #104 and #103 on November 17, 2015.
The drugs were not administered in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs were administered to the resident in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

Resident #021 had a history of demonstrating responsive behaviours. A review of the Minimum Data Set (MDS) assessments completed did not complement each other related to mood and behaviour patterns. The assessment completed in March, 2015, identified that the resident demonstrated three behaviours each at least one to three times in the past seven days and that the behaviours were not easily altered; however, the assessment completed in June, 2015, noted that the resident now only demonstrated one behaviour which was easily altered, yet staff noted that the resident did not have a change in behavioural status in the past 90 days. The resident did have an improvement in behavioural status which was confirmed during an interview with registered staff #112. Registered staff #112 also confirmed that the June 2015, assessment was not integrated for indicators of mood. The assessment noted that the resident demonstrated seven indicators of depression, anxiety or sad mood but also noted that they had no mood indicators. [s. 6. (4) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care for resident #014 was not based on an assessment of the resident's dental and oral status.

A review of the resident's MDS assessment dated October, 2015, stated the resident required daily cleaning of teeth or dentures. A review of the resident's most current care plan and kardex demonstrated that there was no mention of the resident's oral care needs. The care plan did not identify the residents oral status to indicate that the resident had natural teeth. The Director of Care (DOC) confirmed that this information should be identified in the resident's care plan or kardex. [s. 26. (3) 12.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

According to the clinical record, resident #021 was involved in an incident involving a co-resident in October 2014. Registered staff #105, who documented the incident in the progress notes of resident #021 was interviewed and identified the co-resident as resident #099. A review of the clinical record for resident #099 did not include any notation of the incident, any actions taken nor the resident's response, which was confirmed during an interview with the ED. [s. 30. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who had fallen had a post fall assessment completed using a clinically appropriate assessment instrument that was specifically designed for falls.

In November 2015, resident #019 had an unwitnessed fall. A review of progress notes included a description of the event and the assessment of the resident. The clinical record did not include a post fall assessment using a clinically appropriate assessment instrument. Interview with DOC confirmed that the resident did not receive a post fall assessment using a clinically appropriate assessment. [s. 49. (2)]

Issued on this 11th day of January, 2016

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

Original report signed by the inspector.