Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 10, 2020	2020_556168_0003	000133-20, 000535-20	Complaint

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

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

LISA VINK (168), LESLEY EDWARDS (506)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 30, 31, 2020 and February 3, 5 and 6, 2020.

This Complaint Inspection was conducted related to logs:
000133-20 - related to nursing and personal support services; and
000535-20 - related to responsive behaviours.

This inspection was conducted concurrently with Critical Incident Inspection 2020_556168_0004.

PLEASE NOTE: A Voluntary Plan of Correction (VPC) to Long Term Care Homes Act (LTCHA), 2007, chapter (c.) 8, section (s.) 20(1), identified in a concurrent Critical Incident System inspection, report number #2020_556168_0004, with the same date, was issued in this report.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the ED in training, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a care giver, family members and residents.

During the course of the inspection, the inspectors observed the provision of care and services and reviewed records which included but were not limited to policies and procedures, training records, bathing schedules and clinical health records.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 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. (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. (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).

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 failed to ensure that the a written plan of care for residents, included the planned care related to their activities of daily living.

A. Resident #011 was observed to be transported to their room for toileting on an identified date in January 2020.
The following day the resident was observed to receive a level of assistance at two different meal times.
A review of the current plan of care did not include the care need or level of assistance required by the resident for the activities of daily living (ADL) related to eating or toileting, as confirmed by PSW #100 and the ADOC.
The ADOC, confirmed the expectation that the plan of care included the planned care for the resident related to their ADLs.

B. A review of the current plan of care for resident #010 did not include the planned care or level of assistance needed for bathing.
Interview with an individual identified that the resident enjoyed a method of bathing and in their opinion the activity relaxed them.
Interview with PSW #100 confirmed that the resident was routinely bathed by a specific method.
Interview with the DOC, following a review of the plan of care, confirmed that the planned care of bathing was not included in the written plan.

The written plans of care did not include the planned care for the residents related to their ADLs.

2. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident related to responsive behaviours.

A. According to resident #001's progress notes, they exhibited several instances of four specific responsive behaviours.
The progress notes also identified that the resident had two specific responsive behaviours.
The written plan of care only included the presence of the two specific responsive behaviours and not other identified behaviours, which was confirmed by RN #110 and PSW #112.
A review of the written plan of care, which front line staff used to direct care, did not include the identified behaviours noted above, which was confirmed by the DOC.

B. According to resident #003’s progress notes, they exhibited an incident of a specific responsive behaviours.
An interview with the ADOC confirmed that the resident had the potential to demonstrate the behaviour under specific situations.
A review of the written plan of care, which front line staff used to direct care, did not include that the resident had the potential to demonstrate the behaviour, which was confirmed by the DOC.

The plans of care did not include the planned care for the residents related to their responsive behaviours.

3. The licensee failed to ensure that the written plan of care for resident #012 provided

clear direction to staff who provided care related to bathing.

A review of the plan of care noted that the resident had an identified cognitive function due to a diagnosis.
A focus statement related to bathing included a goal that they would receive a comfortable bath/shower/bed bath through the next review.
Interventions for bathing included that the resident required staff assistance and directed staff to refer to the bath/spa book for bath/shower schedule; however, no preferred method was identified.
Interview with the resident identified their preference was for one method of bathing but that at times liked a second method.
Interview with PSW #101 identified that due to a medical condition at times the resident was given the second method of bathing, for safety.
Interview with PSW #100 identified that the resident's preference was for the first method identified by the resident.

The plan of care did not provide clear direction to staff who provided care related to bathing.

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #013 so that their assessments were consistent with each other related to responsive behaviours.

The resident demonstrated responsive behaviours according to the progress notes and as a result a behavioural tracking tool was initiated on an identified date in November 2019.
A review of the tracking tool noted that no behaviours were observed on two dates in November 2019.
A progress note dated in November 2019, included that the resident demonstrated a behaviour and staff intervened.
A progress note later in November 2019, identified that the resident demonstrated a behaviour and staff intervened.
The DOC, following a review of the tracking tool and the progress notes confirmed that the two assessments were not consistent with each other and indicated that, in and around November 2019, the staff had received training regarding the tool and how to complete the documentation.

The assessments related to responsive behaviours were not consistent with each other.

5. The licensee failed to ensure that residents were reassessed and the plans of care reviewed and revised when the resident's care needs changed related to their ADLs.

A. A review of the current plan of care identified that resident #012 required a level of assistance from time to time with eating and a level of assistance with equipment for toileting.
Observation of the lunch meal, on an identified date in January 2020, identified that the resident was provided a higher level of assistance at meal time.
Interview with PSW #100 confirmed that the resident required the higher level of assistance at meal times, approximately 90 percent of the time.
Interview with the resident noted that they required a specific level of assistance with toileting, which was confirmed by PSW #100, which was not consistent with the level in the plan of care.
The ADOC identified that recently they had observed the resident at meal times and they required different levels of assistance.
A review of the plan of care by the ADOC identified that based on observations at meal times, and the statements of staff and the resident related to toilet use, that the plan of care was not reviewed and revised with the changes in care needs.

B. A review of the current plan of care identified that resident #010 required an identified level of assistance at meal times, with a revision date in 2018.
A review of the Minimum Data Set (MDS) assessment, dated in December 2019, noted that the resident a higher level of assistance with eating than recorded on the plan of care.
Observation of the breakfast and lunch meal on an identified date in January 2020, identified that the resident was provided the higher level of assistance, which was confirmed by PSW #100.
A review of the MDS assessment and plan of care by the ADOC identified that the plan was not revised with the change in care needs.

The plan of care was not reviewed and revised with changes in the resident's ADLs.

6. The licensee failed to ensure that resident #013 was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to responsive behaviours.

A review of the progress notes for resident #013 for six months, identified that they

demonstrated responsive behaviours towards a specific population and demonstrated a second responsive behaviour.
Documentation also identified that the resident voiced a specific concern in the home on at least three occasions in one week and was encouraged to utilize an intervention.
A review of the current plan of care included a focus statement for responsive behaviours, which was initiated in 2015; however, it did not include the new behaviour, the changes in those impacted by the known behaviour, nor the identified trigger for the resident and interventions for the management of the behaviours or trigger.
Following a review of the plan of care, the ADOC confirmed awareness of the resident and their behaviours and that the plan of care was not reviewed and revised with changes in responsive behaviours.

The plan of care was not reviewed or revised with changes in the resident's care needs related to responsive behaviours.

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 plan of care set outs the planned care for the resident; 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 are consistent with each other; and to ensure that residents are reassessed and the plans of care are reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident’s hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee failed to ensure that residents were bathed by the method of his or her choice, including tub baths, showers, and full body sponge baths, unless contraindicated by a medical condition.

A. Interviews with PSW #100 and an individual, identified that it was the preference that resident #010 received bathing by a specific method.
A review of the Point of Care (POC) records for approximately two months, noted that the resident received 26 occasions of the desired method of bathing and one occasion which was not their known choice.
PSW staff reported that the resident might have received the bathing on the specified date as the home worked below their desired staffing complement.

B. The plan of care identified that resident #011 had a preferred method of bathing.
Interview with PSW #100 identified that the resident preferred a method of bathing.
A review of the POC records for approximately two months, identified that they received 13 occasions of the desired method of bathing and 14 occasions of a method which was not their known choice.

The resident was not consistently bathed by the method of their choice.

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 are bathed by the method of his or her choice, including tub baths, showers, and full body sponge baths, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that, resident #010, who exhibited altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A progress note, written by RPN #107, on an identified date in December 2019, identified that resident #010 had a area of altered skin integrity according to an individual and that an intervention was completed.
A review of the clinical record including progress notes, assessments and photographs of skin and wound assessments did not include an assessment of the area.
Interview with the ADOC, who was the skin and wound champion, following a review of the clinical record, identified that they were not able to locate an assessment of the area when it was identified.
Interview with RPN #107 confirmed that they did not assess the resident's reported area of altered skin integrity due to the resident's location. They reported the concern to the next shift for follow up and assessment.
There was no further documentation regarding the concern until a note approximately one week later, when the intervention was located in the resident's room and the resident had a symptom.
The resident's skin was assessed the following day and was noted to be clear.

The reported area of altered skin integrity was not assessed by a member of the registered nursing staff with a clinically appropriate assessment instrument.

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 exhibit altered skin integrity, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #4: 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 :

The licensee failed to ensure that actions taken to meet the needs of resident #013, with responsive behaviours, included interventions and documentation of the resident's responses to the interventions.

A review of the progress notes identified that the resident demonstrated responsive behaviours; however, interventions were not consistently documented nor the resident's response.
i. On an identified date in August 2019, the resident demonstrated a responsive behaviour. An assessment was completed, no injuries were noted. There were no documented interventions identified nor the resident response.
ii. On an identified date in November 2019, the resident demonstrated a responsive behaviour. The resident was re-instructed. The resident then demonstrated a second responsive behaviour. The incident was reported the incident to the RN; however, there was no further documentation regarding the incident, interventions nor the resident's response.
iii. On a second occasion in November 2019, the resident demonstrated a responsive behaviour. No interventions were recorded; however, the record noted that there were no further episodes that shift.
iv. On a third occasion in November 2019, the resident demonstrated a responsive behaviour. A co-resident was removed from the area and the DOC and RN were informed. A review of the notes and the responsive behaviour huddle did not include interventions to manage the behaviour of resident #013; however, noted that behavioural tracking was in place.
v. On an identified date in December 2019, the resident demonstrated a responsive

behaviour. No interventions were identified in the progress notes recorded by RPN #114. On review of the notes the RPN confirmed that they did intervene at the time of the incident with success in managing the situation; however, failed to document their actions and the resident's response.
vi. On a second occasion in December 2019, the resident demonstrated a responsive behaviour. No interventions were identified in the progress notes recorded by RN #106; however, the record noted that behavioural tracking was in place. On review of the notes the RN confirmed that they did intervene at the time of the incident with success in managing the situation; however, failed to document their actions and the resident's response.
Interview with the DOC confirmed awareness that staff intervened when the resident demonstrated responsive behaviours; however, in the examples above the interventions nor the resident's responses were documented.

Not all actions taken to meet the needs of the resident with responsive behaviours and their response was documented.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

The licensee failed to ensure that resident #010 was offered a between-meal beverage on an identified morning.

The distribution of morning beverage nourishment was observed on an identified date in January 2020.
Resident #010 was observed to be seated just outside of the lounge area.
The resident was not observed to be offered a morning beverage.
Interview with PSW #102, who served the nourishment on the identified shift confirmed that due to an oversight they did not offer the resident a beverage.
A review of the POC records for "nutrition snacks, % of snack taken between meals" noted that the resident took 0-25 percent (%) of the identified morning.
The ED in training confirmed the expectation that all residents were offered a between meal beverage in the morning.

The resident was not offered a between meal beverage on an identified date.

Issued on this 11th day of February, 2020

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

Original report signed by the inspector.