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 soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 25, 2017	2017_594624_0013	011739-17	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

FENELON COURT
44 WYCHWOOD CRESCENT FENELON FALLS ON K0M 1N0

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

BAIYE OROCK (624), DENISE BROWN (626), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 10, 11, 12, 13, 14, 17, 18, 19, and 20, 2017

The following logs were inspected concurrently:
Log #008172-17 – related to an allegation of resident abuse,
Log #029891-16 – related to a complaint about staffing levels in the home.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), the Regional Manager for Education and Resident Services, the Regional Manager for Clinical Services, the RAI Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the president of Residents' Council, a member of the Family Council, residents, and family members.

A tour of the home was carried out, an observation of medication administration, several meal services, staff to resident and resident to resident interactions was made. A review was also completed of residents' health records, the Licensee's internal investigations and relevant policies and procedures related to minimizing of restraints, personal assistance services device (PASD), zero tolerance to abuse and neglect, medication incident and adverse drug reactions reporting, and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care
Sufficient Staffing

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

5 WN(s)
1 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. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Related to log #029891-16,

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program related to the performance of hand hygiene during dining room meal service.

Dining room observations were conducted on two consecutive days in 2017 on the Sturgeon Bay unit. During these dining observations, PSW #107 failed to perform hand hygiene during the meal services for breakfast and lunch on the first day and breakfast on the second day.

On July the first day, during the breakfast meal service Inspector #626 observed PSW #107 simultaneously feeding residents # 005, #022 and #026 at one table, and residents #042 and #015 at another table without performing hand hygiene. PSW #107 did not perform hand hygiene during the entire meal service including during serving, feeding

and clearing of dirty dishes.

During the lunch meal service on the first day, Inspector #626 observed PSW #107 simultaneously feeding resident #015 at a table and residents #005, #022, and #026 at another table without performing hand hygiene. At a period during the meal service, PSW #107 was observed feeding resident #005, #015, #022, and #026, giving each resident one spoon at a time, while moving back and forth between the two tables without performing hand hygiene. In the same meal service, Inspector #626 also observed PSW #107 removing dirty dishes from two other tables and then returning to the first two tables where PSW #107 resumed feeding the residents without performing hand hygiene.

In an interview on the first day after the lunch meal service PSW #107, indicated that she (PSW #107) did not perform hand hygiene during the meal service.

On the second day, PSW #107 approached Inspector #626 while the Inspector was outside of the dining room observing the breakfast meal service and inquired if she (PSW #107) should perform hand hygiene between feeding residents. Inspector #626 indicated that PSW #107 was required to follow the home's practices. PSW #107 was not observed to perform hand hygiene during the entire meal service.

During separate interviews a day after the initial observations were made, PSW #108 and PSW #116, both indicated that hand hygiene is performed upon entering the dining room, between feeding residents and after removing dirty dishes from the tables.

In an interview on the second day of observation, the ED/DOC, indicated that employees were provided training on the performance of hand hygiene. The ED/DOC also indicated that PSWs can feed up to two residents at a time, while providing cueing assistance to other residents. In the same interview, the ED/DOC also indicated that PSW #107 did not follow the expectations for hand hygiene while providing assistance to residents in the dining room.

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program pertaining to PSW #107 not performing hand hygiene during the observed dining room meal services. [s. 229. (4)]

2. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of

this screening are available to the licensee.

Review of Infection Prevention and Control LTCH Licensee Confirmation Checklist indicated that: question #1 - Is each resident admitted to the home screened for tuberculosis (TB) within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee? The licensee response was "No".

During an interview, the ED/DOC indicated that she was aware that there is a gap in the process for TB screening within 14 days of admission. The ED/DOC indicated that the home stopped doing 2-step TB skin testing on admission for residents over the age of 65 as indicated by Haliburton, Kawartha, Pine Ridge District Health Unit, several years ago, that a chest x-ray was the preferred method for screening.The ED/DOC indicated that it has been difficult to ensure residents receive a chest x-ray prior to admission and once they are admitted to the home it is even more difficult. There is no mobile x-ray service available to the home and residents are required to travel to the closest centre to have this x-ray completed. There is a local x-ray and ultrasound service but it is not accessible and unless the resident is able to get on the table unassisted, then they cannot have the x-ray completed there. As a result, if the resident did not receive a chest x-ray prior to admission then it likely wound never happen. The ED/DOC indicated that there are identified gaps in the TB screening for the home and that of the 18 residents admitted to the home since a specified date in 2016, only five residents have confirmed chest x-rays.

On an identified date and time during an interview, RN #105 indicated that 13 of the 18 residents that have been admitted to the home since the specified date in 2016 were not screened for TB within 14 days of admission or had not received a chest x-ray within 90 days prior to the admission. All 13 residents have orders from admission for TB screening and the orders were not completed.

A review of the clinical records for all current residents of the home that were admitted after the specified date in 2016 was completed. Of the 18 residents admitted, 13 residents did not receive TB screening within 14 days of admission or within 90 days prior to admission and the documented results of the screening are available to the licensee.

3. The licensee has failed to ensure that residents were offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded

immunization schedules posted on the Ministry website.

Review of the clinical records in the home indicated that there were 18 residents admitted to the home since a specified date in 2016. There is no documented evidence that any of the residents were offered immunization against tetanus and diptheria (Td). Clinical records were reviewed for the 18 newly admitted residents and 11 of the residents did not have documented evidence of current immunization against Td.

A review of the clinical records for the 18 residents admitted to the home since the specified date in 2016, indicated that for 13 of the residents, there was no documented evidence the residents were offered the immunizations against pneumococcus and the 13 residents' clinical records reviewed did not provide documented evidence that the residents had ever received immunization against pneumococcus.

On a specified date and time, during an interview with Inspector #623, RN #105 indicated that there was a process in place where on admission residents or the SDM were asked to sign separate order forms which included consent for tuberculosis screening on admission, as well as offering pneumococcus, tetnus and diphtheria immunization in accordance with the immunization schedules. RN #105 further indicated that it appears as though a new process for admission orders was implemented and in doing so the consent and order sheets for tetnus and diptheria were no longer offered to residents.

RN #105 indicated that 11 of the 18 residents admitted since the specified date in 2016 did not have a history of a tetnus/diptheria immunization in the last 10 years and that this vaccine was not offered to the residents on admission. RN #105 also indicated that 13 of the 18 residents admitted since the specified date in 2016 did not have a history of ever receiving a pneumococcus immunization, that the immunization was ordered by the physician on admission and the immunization was not given.

On a specified date and time, in an interview with Inspector #623, the ED/DOC confirmed that there are identified gaps in the immunization program in the home. The expectation, she indicated, is that all residents will be screened on admission and immunizations will be offered and administered where indicated, in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 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 to ensure that staff adhere to hand hygiene practices in the home, all newly admitted residents are screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, and that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident related to resident #015.

Resident #015 was admitted to the home on a specified date with a specified diagnosis. The resident was observed using a mobility aid that was being used in a particular manner on a specified date and time. A review of resident #015's health records indicated that the plan of care did not identify the use of the mobility aid in the manner in which it was observed to be in use.

A review of the current written plan of care of resident #015 did not specify how the said mobility aid was to be used nor did it specify any monitoring of the use of the mobility aid.

In an interview on a specified date with RN #100 and another interview with RPN #102 on another specified date, both indicated that the mobility aid and instructions for monitoring was not mentioned in the resident's current plan of care. During another interview with PSW #103 on a specified date and PSW #106 on another date, both indicated that the mobility aid and instructions for monitoring resident #015 was not in the resident's current plan of care.

In an interview with the ED/DOC on a specified date, the ED/DOC indicated that the mobility aid and instructions for monitoring the resident were not in the plan of care and should have been identified in the plan of care.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that:
Includes identification of causal factors, patters, type of incontinence and potential to restore function with specific interventions, is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #035 was admitted to the home on a specified date with a specified diganosis. Review of the clinical records indicate that resident #035 was cognitively able to make informed decisions.

Review of the clinical records indicated that there was no physical examination completed by a physician or Nurse Practitioner (NP) on record since admission on of the resident. The admission progress notes indicated that resident #035 was admitted to the home with a particular intervention in place related to continence care. A continence assessment was completed on admission by RPN#112 that identified resident #035 as continent due to the intervention the resident was admitted with.

During an interview with resident #035, the resident described the circumstance under which the identified intervention was started but said things have change since being admitted into the home. Resident #035 indicated in the same interview that since admission, no one has discussed the continued need of the said intervention.

Review of the policy LTC-E-50 Continence Care (revised May 2013), under assessment indicated
The Nurse will:
1. review the residents relevant medical history associated with continence.
2. complete the 24 hour admission assessment/care plan to identify level of continence
3. Initiate the 3 day continence assessment on admission and /or if there is a change in level of continence.
4. Determine if the resident is a candidate for a continence restorative care program.

During an interview on a specified date, the ED/DOC indicated that resident #035 was admitted with the intervention. The ED/DOC was not certain why the resident needed the intervention or if the resident was assessed for the continued need of the intervention since being admitted into the home. The ED/DOC indicated that resident status had

changed since the intervention was initiated and that the ED/DOC recently met with resident #035 regarding the intervention and that the resident expressed a desire to look at the options of having the intervention discontinued. The ED/DOC indicated that she would make arrangements for the NP to follow up with resident #035. [s. 51. (2) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. Related to log #02989-16,

The licensee has failed to ensure that no person simultaneously assists more than two residents who need total assistance with eating or drinking.

Dining room observations were conducted on two consecutive days at the Sturgeon Bay unit. On the first day during the breakfast meal service Inspector #626 observed PSW #107 simultaneously feeding residents # 005, #022 and #026 at one table, and residents #042 and #015 at another table, all of whom required total assistance with feeding except resident #042 who required cuing. On the same day, during the lunch meal service, Inspector #626 observed PSW #107, simultaneously feeding residents #015 at one table, and residents #005, #022 and #026 at another table. The PSW was observed feeding resident #005, #015, #022 and #026 giving each resident one spoon of food at a time, while moving back and forth between the two tables.

During the lunch service there was a dietary aide in the servery, two PSWs (#107 and #108), one volunteer, and one Activity Aide (AA) #121. There was also one visitor who was observed assisting resident #042. The AA#121 was observed feeding resident #022 for a short time, before PSW #108 began feeding the resident. PSW #108 was observed serving residents in the dining, then left the dining room fifteen minutes before the completion of the meal service to provide tray service to resident #018 who was in

his/her room.

In an interview on the first day of observation, after the lunch meal service, PSW #107 indicated that according to the Ministry's standard, no more than two residents should be fed at a time. The PSW also indicated that there was not enough time during the meal service to feed two residents at a time.

In an observation of the dinner meal service on the same day with a similar staffing complement, PSW #118 and PSW #119 were present in the dining room and fed no more than two residents at a time, still completing the dining service in a timely manner.

During separate interviews conducted with PSW #108 and PSW #116, two days after the initial observation, both indicated that no more than two residents must be fed at a time.

In an interview on the day after the initial observations, the ED/DOC, indicated that it is the home's expectation that employees are required to feed two residents at a time and may provide cueing assistance to other residents. In the same interview, the ED/DOC also indicated PSW #107 did not follow the home's expectations for feeding residents who require assistance with feeding.

The licensee has failed to ensure that no more than two residents are fed simultaneously during the dining room meal service. [s. 73. (2) (a)]

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident was reported to the resident's substitute decision maker (SDM) and/or the resident's attending Physician or the registered nurse in the extended class attending the resident for resident #009 and #050.

Inspector #624 reviewed two medication incident report completed by the home on a specified date (for resident #050) and another specified date (for resident #009) and the reports indicated that resident #050 was given the wrong dose of a medication while resident #009 received an extra dose of a medication.

According to both medication incident reports, both residents were assessed following the incidents and there was no injury or adverse effects suffered by the residents as a result of the incidents. The incident reports also indicated that for resident #009, the resident's substitute decision maker (SDM) and the resident's attending Physician or the registered nurse in the extended class attending the resident was not informed of the medication incident. Regarding resident #050, the attending Physician or the registered nurse in the extended class attending the resident was not notified of the incident. A review of the progress notes for both residents around the time of the incident revealed no documentation related to the medication incidents.

In separate interviews with Charge Nurse RN #100 and the ED/DOC on a specified date, both indicated that the home's expectation when there has been a medication incident involving a resident is to have the a medication incident report completed, the resident, the resident's SDM, the Physician or Nurse Practitioner, and the Pharmacy provider informed of the incident. Both RN #105 and ED/DOC, after reviewing both medication incident reports, could not provide any documentation to indicate that the resident's SDM and/or Physician was notified of the above medication incidents for both residents as required. [s. 135. (1)]

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Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 28th day of August, 2017

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

Original report signed by the inspector.