Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 13, 2016	2016_271532_0009	007198-16	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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE KITCHENER ON N2N 2A8

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

NUZHAT UDDIN (532), DOROTHY GINTHER (568), MARIAN MACDONALD (137), SHARON PERRY (155)

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): March 21, 22, 23, 24, 30, 31 2016 and April 1, 4, 5, 6, 7, 8, 11, 2016.

Concurrent Critical Incident System (CIS) and complaints were completed: CIS: 021877-15, 022034-15, 022346-15, 027019-15, 028241-15, 030193-15, 031040-15, 035290-15, 011667-15, 021518-15, 025190-15, 000560-15, 022927-15, 034315-15, 029812-15, 003145-16, 009053-14, 022354-15, 033648-15, 036030-15, 013561-15, 006692-16, 005529-16, 000531-16, Complaint: 033972-15, 035963-15, 035456-15, and a follow-up to an order 023209-15.

During the course of the inspection, the inspector(s) spoke with 1 Executive Director, 1 Director of Care, 2 Associate Director(s) of Care, 5 Registered Nurses (RN), 1 Food Service Manager, 1 Environmental Service Manager , 1 Recreation and Program Services Manager, 2 Resident Care Managers, 2 Resident Assessment Instrument (RAI) Coordinators, 1 Behaviour Support Ontario Staff (BSO), 11 Registered Practical Nurses (RPN), 26 Personal Support Workers (PSW), 2 Laundry and Housekeeping Aide, 1 Receptionist, Family and Resident Council Representatives, 40+ Residents and 5+ Family members.

The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures, reviewed educational records, general maintenance of the home, and resident communication system, medication storage areas, and reviewed medication records as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **8 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 148. (2)	CO #001	2015_438171_0002	532

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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During stage one of the Resident Quality Inspection (RQI), an identified resident indicated that they were hit by another identified resident.

Another identified resident who witnessed the incident between the two residents reported the name of the alleged resident.

In an interview with an identified staff member resident's allegations were validated as they remembered the incident.

The home's Policy called Non-Abuse, indicated under immediate interventions following allegations of resident abuse. In cases of physical and/or sexual abuse, it was imperative to preserve potential evidence as the complaint may result in criminal charges staff were to ensure that accurate detailed description of injuries/condition was documented in the resident chart.

Record review indicated that there was no risk management report completed for the identified resident and there was no documentation with a detailed description of injuries as stated in the policy.

DOC confirmed that the expectations was that whenever there was a resident to resident altercation there was a risk management report completed for both of the resident and an assessment of the resident was to be documented with detailed description of injuries and condition and it was not done and the policy 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. 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 licensee failed to ensure that residents were free from neglect by the licensee or staff in the home.

During an interview with the identified resident, they reported that an identified staff had hit them on the arm and it made them feel like a child.

Another identified resident was interviewed and they revealed that they witnessed the incident.

Record review revealed that both of the identified residents had reported the same information to the home that they reported to the Inspector.

The Assistant Director of Care confirmed that the home's investigation revealed that the identified staff member had slapped the resident on the hand.(155)

During stage one of the Resident Quality inspection (RQI), an identified resident

indicated that an identified staff member had yelled at the resident when the identified resident had requested to go the bathroom.

The identified resident again confirmed the allegations and stated that they found the yelling to be "rude" and "unnecessary".

During an interview the identified staff member acknowledged that they had to raise their voice as the identified resident was impatient and wanted things done immediately.

The identified staff met with the DOC and they acknowledged yelling at the identified resident out of frustration.

The DOC informed the Inspector that the education was provided to the identified staff in terms of Non-abuse,and confirmed however, the identified resident was not protected from abuse. (532)

Record review revealed that an identified resident reported that the identified staff member was unable to find a assistive device and advised them to go in their brief. The identified resident reported that they called again and another identified staff answered the call bell. The identified staff member advised the resident that they would return but never came back. When the next shift staff arrived they discovered the identified resident to be incontinent.

Record review indicated that the call bell in the identified resident's room was activated three times on the shift.

Review of the resident's plan of care revealed that the identified resident used an assistive device at their request and was to be toileted during the day.

The resident indicated that they had not gone in their brief since they were a baby and was quite upset by the incident.

Review of the investigation records revealed that an identified staff member acknowledged that they were unable to find an assistive device and had told the identified resident that they would just have to change them.

The Assistant Director of Care (ADOC) acknowledged that the identified resident should not have had to wait to be toileted, and confirmed that the resident had been neglected.

(568)

Record review identified that an identified staff member was witnessed yelling at an identified resident using an angry tone.

Record review revealed that an identified staff member reported to the DOC that as a result of an identified resident's actions, the staff member was angry and had spoken sternly with the identified resident.

Record review of the resident's plan of care revealed that the identified resident had a history of specific responsive behaviours and the interventions to manage these behaviours included a calm and gentle approach, allow resident time to respond to questions, when resident exhibits specific behaviours, re-approach later.

Resident Care Manager (RCM) confirmed that the resident was not protected from abuse by the staff member. [s. 19. (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 long term care home shall protect residents from abuse by anyone and shall ensure residents were free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to report and locate residents' lost clothing and personal items.

An identified resident shared that they had three khaki pants and was able to found two of them, however, one was still missing.

An identified resident reported that he had missing underwear and socks.

An identified resident shared that they had list of items that were missing and there was at least a t-shirt and pair of socks missing.

Observation of the lost and found items inside the laundry room revealed the following:
three- overfull Rubbermaid type tubs full of socks, underwear and residents clothing.
two- full racks of resident personal clothing i.e. pants shirts and jackets.
one- industrial type laundry cart full of blankets and large items and
one- two tier shelf full of large size crosier blankets and
one- closet/shelf unit full of blankets and personal items.

The Environmental Service Manager (ESM) shared that when a resident reports a missing item they complete a Client Service Response (CSR) Form, however, there was no formal written process to report and locate residents' lost clothing and personal items. He shared that he puts the lost and found out each month for a week by the recreation office for the residents and family members to examine.

The Executive Director (ED) confirmed that none of the identified residents that complained of missing clothing during the Resident Quality Inspection had a CSR form completed.

In an interview an identified RPN reported on the process for the missing clothing and personal items and shared that they would make a progress note, look for the missing items in the lost and found and call down to reception to complete a form.

An interview with an RN shared that she would look for the missing items, although, she was not aware of any forms that were available on the home area as she never had to complete one, however, she would take the family member down to reception and have the family member complete a complaint form.

The ED confirmed that the process to report and locate residents' lost clothing and personal items needed to be reviewed with the registered staff as family members do not complete the CSR forms. The form was available on the home areas for the registered staff to complete for when any concerns are raised. [s. 89. (1) (a) (iv)]

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 there was a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Observations, during the initial tour and throughout the Resident Quality Inspection (RQI), revealed identified deficiencies, such as damaged and paint chipped doors, door frames, walls, wall protector and ceiling tiles in 21 of 31 (68 per cent) resident rooms.

A review of the Quarterly Routines Painting Policy, revealed the routine, preventive and remedial maintenance program included a procedure to identify areas to paint and/or repair.

During a tour and interview, the Environmental Services Manager confirmed the identified deficiencies and acknowledged the home's expectation was that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. [s. 90. (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 the home, furnishings and equipment were maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: 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. (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 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 change or care set out in the plan was no longer necessary.

An identified resident expressed pain in an identified area, was being monitored and given regular doses of pain medication, as well as PRN (as needed) analgesics.

The attending physician indicated, that due to the identified diagnosis, therapy and analgesics were the only forms of treatment available.

A clinical record review, for the resident, revealed there was no documented evidence that the pain and pain management interventions were identified on the plan of care.

During an interview with the Registered Nurse (RN), it was confirmed that pain and pain management interventions were not identified on the plan of care and the plan of care was not reviewed and revised when the identified resident's care needs had changed.

During an interview with Director of Care it was acknowledged that the home’s expectation was that, when a resident was experiencing new or chronic pain, pain and pain management interventions would be identified on the plan of care and it was not done. (137)

An identified resident was assessed to be at a high risk for falls.

Review of the identified resident's care plan revealed specific interventions for falls.

The identified resident was observed and the interventions were not in place.

Observations were confirmed with the identified resident and a staff member and they both indicated that the interventions were no longer in place as they are not necessary.

Interview with the Registered Nurse confirmed that the identified resident no longer required the interventions and confirmed that the expectation was that the plan of care was to be revised for the resident when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #6: 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences for the resident.

An identified resident indicated that they preferred to sleep in the morning.

An interview with an identified staff member it was revealed that the residents who go down to the main dining room were to get up before the other residents. The identified staff confirmed that the resident did get up early.

Record review revealed that there was no plan of care or an interdisciplinary assessment of the identified resident's sleep patterns and preferences.

An identified RN confirmed that there was no plan of care for identified resident sleep pattern and shared that they would work on it.

The DOC verified the expectation and acknowledged that the plan of care for the identified resident should include sleep patterns and preferences based on an interdisciplinary assessment of the resident and confirmed that it was not done. [s. 26. (3) 21.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

An identified resident expressed that they have not had a care conference since being admitted into the home.

Record review done revealed that the resident was admitted to the home on an identified date. Record review revealed that there was no documentation regarding a six week care conference.

The Resident Services Coordinator confirmed that there was no care conference held for the identified resident within six weeks of their admission. [s. 27. (1) (a)]

WN #8: 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,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident, who was incontinent and has been assessed as being potentially continent or continent some of the time, received the assistance and support from staff to become continent or continent some of the time.

Review of plan of care for an identified resident stated that the identified resident was on toileting program for incontinence. The plan of care further stated that the toileting plan was to be offered, every two hours.

In an interview the identified resident reported that they toilet themselves and put the call bell on when they required the assistance from staff.

Observation revealed that the identified resident was not offered toileting and this was confirmed with the resident.

An identified staff member acknowledged that the resident was competent and could toilet independently and would ring the call bell to notify staff and staff would check on the identified resident.

Another identified staff member acknowledged that the resident was not toileted by the staff as the identified resident was independent with toileting.

Record review of the progress notes revealed that the resident expressed to an identified RPN that they felt that the staff coming to the resident every two hours would be effective in promoting continence.

The Associate Director of Care (ADOC) confirmed that the expectation was for the staff to approach the identified resident and offer the assistance and support to promote continence and this was not done. [s. 51. (2) (d)]

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Issued on this 13th day of April, 2016

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

Original report signed by the inspector.