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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 25, 2014	2014_031194_0009	000157, 001196, 001002	Complaint

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

FOSTERBROOKE
330 KING STREET WEST, NEWCASTLE, ON, L1B-1G9

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

CHANTAL LAFRENIERE (194), PATRICIA POWERS (157)

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): March 5, 6 & 7, 2014

During the course of this inspection three complaint logs were inspected; Log # O-001196-13, #O-001002-13, #O-000157-14

During the course of the inspection, the inspector(s) spoke with Director of Care(DOC),RAI Coordinator,Registered Dietitian(RD),Nutritional Care Manager(NCM), Registered Nurse (RN), Registered Practical Nurse (RPN)and Personal Support Worker (PSW)

During the course of the inspection, the inspector(s) reviewed clinical health records, Medication Administration Records (MARS), RAI MDS documentation, Nutritional intake records, Treatment Administration Records (TARS) of identified residents. Reviewed staffing complements and staffing replacement processes, reviewed licensee policies "Dementia Care" LTC-E-100, "Disclosure of Adverse Events" LP-C-70,"Pain Assessment and Symptom Management" LTC-E-80, "Revera Skin & Wound Program" LTC-E-90. Observed resident/staff interaction and provision of care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s.6.(1)(c)when the written plan of care for Resident #01 did not set out clear directions to staff and others who provide direct care to the resident related to palliation, pain, wound care and hydration.

-MDS "Significant Change of Status" Assessment for resident #01 on an identified date states the following:
- resident has a wound, receives dressing changes and is monitored by the facility treatment nurse
- resident has a specialized equipment for bed and chair
- resident is turned and repositioned q2h
- resident is at increased risk of dehydration

-Plan of care for Resident #01 indicates daily fluid intake requirement of 1900 - 2400 ml. Daily fluid intake records indicate that the resident's fluid intake over a two week period was significantly below the established daily requirement.

The written plan of care for Resident #01, in place at the time of the change in condition, failed to provide clear direction related to interventions for comfort, wound management or hydration needs. Comfort measures for resident #01 identified in the RAI MDS assessment are not identified on the resident's written plan of care. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA, 2007 s. 6(5) when the substitute

decision-maker (SDM) for Resident# 01 was not provided the opportunity to participate fully in the development and implementation of the resident's plan of care.

The progress notes for Resident #01 over a three week period indicate a change in skin condition.

Family communication in the progress notes indicate the family was made aware of a change in condition for Resident #01 three weeks after assessment.

March 5, 2014 - Interview with staff member #102 - states she is sure that resident's son was informed of the wound but was unable to locate any supporting documentation
March 6, 2014 - Interview with RN #106 - does not recall what communication took place with the resident's son - stated he visited frequently - was unable to provide supporting documentation for communication.

Facility Policy "Disclosure of Adverse Events" - LP-C-70 - Revised April 2013 - directs the following:
Standard:
Revera Inc. will disclose adverse events to affected Resident/Client(s), Family and/or duly appointed Substitute Decision Makers (SDM)
Definitions:
An Adverse Event is an unexpected and undesirable incident directly associated with the care or services provided to the Client/Resident. The incident occurs during the process of receiving health care or services. The adverse event is an outcome, injury or complication for the Client/Resident.
Policy:
The individual disclosing the adverse event to the Resident/Client/SDM is responsible for documenting the disclosure. documentation is to include:
a. the time, place and date of disclosure
b. the names of all attendees and their relationship to the Resident/Client
c. the facts presented in the discussion
d. questions raised by the attendees and the answers given
e. action taken or to be taken
f. offers of assistance provided and the response
g. name of Revera individual designated to follow up with Resident/Client/SDM/Family
h. any request from the Resident/Client/SDM/Family to review his/her health record

There is no evidence that resident #01's SDM was informed of the resident's deteriorating wound. [s. 6. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that there is a written plan of care for each resident that sets out;
-clear direction to staff and others who provide direct care to the resident related to; pain, wound care, comfort measures and hydration; and
-shall ensure that the resident, the resident's substitute decision maker, if any, and any other persons designated by the resident are given an opportunity to participate fully in the development of the resident's plan of care, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the Registered Dietitian completed a nutritional assessment for Resident #01 when there was a significant change in the resident's health status:

The progress notes for Resident #01 over a three week period indicate a change in skin condition.

MDS "Significant Change of Status" assessment completed indicates that resident #01 is at increased risk of dehydration.

The plan of care for Resident #01 indicates daily fluid intake requirement of 1900 - 2400 ml. Daily fluid intake records indicate that the resident's fluid intake over a two week period was significantly below the established daily requirement.

Two nutritional assessments were completed for Resident #01. There is no evidence of nutritional assessment related to the resident's declining skin condition or increased risk of dehydration.

Nutritional Care Manager staff #205 confirmed that nutritional care referral had not been made and a nutritional care assessment related to the residents deteriorating skin condition had not been completed. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that a Registered Dietitian who is a member of the staff at the home;
-completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition
-assess any risks relating to nutritional care, hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s.52(2) when Resident #01 was not assessed using a clinically appropriate assessment instrument when the resident's pain was not relieved by initial interventions.

The progress notes for Resident # 01 indicate that the over a 7 day period, analgesics were given to Resident #01 who was experiencing significant pain related to a wound.

Facility policy "Pain Assessment and Symptom Management" - LTC-E-80, Revised August 2012 directs the following:
Assessment:
- If the resident complains of pain, a quick pain assessment on the resident will be completed using PQRST and documented.
- The resident's pain will be measured using a standardized, evidence-informed clinical tool
- the nurse will determine which tool is appropriate based on the resident's cognitive, physical and behavioural characteristics
Pain Monitoring:
- If pain has been identified, a pain monitoring tool will be maintained for 72 hr.
- A pain monitoring tool will be initiated when new regular pain medication is ordered; PRN pain medication is used for 3 consecutive days
Documentation: The resident's care plan will be updated to reflect pain management

There is no indication that a pain assessment tool or pain monitoring tool was put in place for Resident #01 [s. 52. (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 by ensuring that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose., 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 :

1. The licensee failed to comply with O. Reg 79/10 s. 53(4)(a) when the behavioural triggers for Resident #02 were not identified.

RAI MDS on an identified date for Resident #02 states resident was noted to display change in sleep pattern, restless, wandering socially inappropriate and resistive behaviour. These behaviours are not easily altered. Resident #02 can becomes anxious at times receiving medication for moods and behaviours. Resident #02 has a bed alarm on the bed to alert staff. Resident #02's room has also been changed so staff are better able to monitor the resident.

The progress notes for Resident #02 were reviewed for the period of four months with multiple documentation entries related to restless behaviour, wandering into other resident's rooms, socially inappropriate, being physically resistive to staff during care

and not easily redirected

Interview with PSW staff #206 and #207 confirm that Resident #02 is resistive to care, wanders in and out of co- resident's rooms, and is exit seeking.

The plan of care for Resident #02 related to responsive behaviours directs;
-use simple verbal cues to redirect exhibited behaviour
-requires frequent reminders
-use brief, simple consistent words and cues
-simplify task, give one instruction at a time. [s. 53. (4) (a)]

2. The licensee failed to comply with O. Reg 79/10 s. 53(4)(b) when strategies were not developed and implemented to respond to the responsive behaviours of Resident #02

The Plan of Care for Resident # 02 was reviewed related to responsive behaviours and states
Decline in cognitive functioning as evidenced by behaviours exhibited related to Dementia
- Use simple verbal cues to redirect exhibited behaviour
- Requires frequent reminders
- Use brief, simple, consistent words & cues
- Simplify task, give one instruction at a time

RAI MDS assessment on an identified date and Progress notes over a four month period identify;
inappropriate behaviours
resistiveness to care and not easily redirected
Physical aggression towards staff during the provision of care
Wandering in and out of co-resident's room, removing items and agitating other residents [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that for each resident demonstrating responsive behaviours
-the responsive behavioural triggers are identified,
-strategies are developed and implemented to respond to these behaviours, to be implemented voluntarily.

Issued on this 25th day of March, 2014

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

CHANTAL LAFRENIERE (194)