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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_334565_0017	031953-16	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

MACKENZIE PLACE
52 GEORGE STREET NEWMARKET ON L3Y 4V3

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

MATTHEW CHIU (565), KAREN MILLIGAN (650), VALERIE JOHNSTON (202)

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 9, 10, 14, 15, 16, 17, 18, 21 and 22, 2016.

During the course of the inspection, the Critical Incident Intake 005043-16 related to resident fall with injury, and the Complaint Intakes 006408-14, 002319-15 and 020151-16 related to residents' plans of care were inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Resident Assessment Instrument Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Physiotherapist, Residents and Family Members.

The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of resident and home records, meeting minutes for Residents' Council, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Resident Charges
Residents' Council
Skin and Wound Care

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

- **3 WN(s)**
- **2 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 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 has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident.

During the stage one of the Resident Quality Inspection (RQI), the Resident Assessment Instrument – Minimum Data Set (RAI-MDS) assessments revealed resident #002 was incontinent and had a fall.

Review of resident #002's RAI-MDS assessment and plan of care revealed the resident had both cognitive and physical impairments and was incontinent. The plan of care

stated the resident was at risk for falls and required a specified assistance for transfer and toileting. One of the falls prevention interventions stated a toileting schedule established, and it did not specify any time for the schedule. Further, the plan of care also indicated the resident did not require a toileting program because he/she would request for toileting assistance.

Interview with resident #002 indicated he/she would use the toilet by himself/herself and would not ask the staff for assistance. The resident was unable to recollect how the staff assisted him/her for toileting.

Interviews with Personal Support Worker (PSW) #102 and Registered Practical Nurse (RPN) #103 indicated the resident was at risk for falls and one of the contributing factors was resident's unsafe self-transfer for toileting, and therefore a toileting schedule was required. The PSW indicated he/she would toilet the resident routinely three times during his/her shift, and upon the resident’s request. The staff members indicated that the plan of care did not specify a time schedule for offering toileting assistance to the resident.

Interview with the Associate Director of Care (ADOC) indicated that staff members would have to offer toileting assistance to the resident during the hourly safety check, but it was not mentioned in the plan.

Interview with the Director of Care (DOC) confirmed the plan of care did not set out a clear direction for the timing required to offer toileting assistance to resident #002. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Review of a Critical Incident System (CIS) report and progress notes revealed resident #005 fell on an identified date. The fall was unwitnessed and the resident was sent to the hospital on the same day and subsequently diagnosed with a specified significant injury. After the resident returned to the home, he/she fell again twice within two months. An identified physiotherapy post-fall assessment recommended the resident to use a specified medical supply for falls prevention and management.

Review of resident #005’s plan of care indicated the resident was at risk for falls and had

interventions put in place for falls prevention. The plan of care did not indicate the use the above mentioned medical supply for the resident until it was revised after the inspector brought this to staff's attention, seven months after the physiotherapy post-fall assessment.

Interviews with PSW #112 and #113 indicated the resident had been using the specified medical supply for a few weeks. Interview with the ADOC indicated that after an evaluation took place three months ago, registered staff suggested using the specified medical supply to increase the resident's confidence for mobility and to alleviate injury if he/she falls. The resident started using it since a month ago.

Interview with the Physiotherapist (PT) indicated he/she had been involved in the resident's falls prevention and recommended the resident to use the specified medical supply in his/her assessment. The PT did not recollect further follow up with other staff members.

Interviews with the ADOC and the DOC indicated that the PT should have collaborated with other staff members either by documenting in progress notes or communicating verbally about the recommendation. The staff members confirmed there was no evidence for such collaboration had taken place and therefore the resident's plan of care for using the medical supply was not developed at that time. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the plan of care is revised at any time when the resident's care needs change or care set out in the plan is no longer necessary.

Review of a CIS report revealed resident #005 fell on an identified date. The fall was unwitnessed and the resident was sent to the hospital on the same day and subsequently diagnosed with a specified significant injury.

Review of resident #005's progress notes indicated on another identified date, a staff member contacted the resident's substituted decision maker (SDM) about purchasing a specified medical supply for the resident and the SDM consented. Ten days later, the staff member contacted a vendor for ordering the specified medical supply.

Review of resident #005's written plan of care indicated the resident was at risk for fall and had interventions put in place for falls prevention. The interventions did not include the use of the specified medical supply for the resident.

Interviews with PSW #112 and #113 indicated the resident had been using the specified medical supply for a few weeks for his/her falls prevention and this intervention was not in the plan of care. Interview with the ADOC indicated the resident started using the specified medical supply a month ago.

Interviews with the ADOC and DOC confirmed that the resident's falls prevention care needs had changed, and the plan of care was not revised for resident #005 to use the specified medical supply until after PSW #112 and #113 were interviewed by the inspector.

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 is a written plan of care for each resident that sets out clear directions to staff and other who provide direct care to the resident,
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the development of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,
- the plan of care is revised at any time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home.

Review of a CIS report revealed resident #005 fell on an identified date. The fall was unwitnessed and the resident was sent to the hospital on the same day and subsequently diagnosed with a specified significant injury.

Review of resident #005's progress notes indicated on another identified date, a staff member contacted the resident's SDM about purchasing a specified medical supply for the resident and the SDM consented. Ten days later, the staff member contacted a vendor for ordering the specified medical supply.

Interviews with PSW #112, #113, RN #116 and the PT revealed the falls prevention and management for residents in the home includes the use of the specified medical supplies based on a resident's assessed needs. The residents would have to get the specified medical supplies from a vendor as they were not available at the home.

Interview with the ADOC indicated that after receiving the consent from the SDM for the resident to use the specified medical supplies, they were not available at the home until the vendor brought them in 17 days later. Interview with the DOC confirmed that the specified medical supplies were not readily available at the home for resident #005. [s. 49. (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 the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (4) A licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf. 2007, c. 8, s. 91. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee shall not accept payment from or on behalf of a resident for anything that the licensee is prohibited from charging for under subsection (1) and shall not cause or permit anyone to make such a charge or accept such a payment on the licensee's behalf.

Review of a CIS report revealed resident #005 fell on an identified date. The fall was unwitnessed and the resident was sent to the hospital on the same day and subsequently diagnosed with a specified significant injury.

Review of resident #005's progress notes indicated on another identified date, a staff member contacted the resident's SDM about purchasing a specified medical supply for the resident and the SDM consented. Ten days later, the staff member contacted a vendor for ordering the specified medical supply.

Interviews with PSW #112, #113, RN #116 and the PT revealed the falls prevention and management for residents in the home includes the use of the specified medical supplies. The residents would have to get them from a vendor as they were not available at the home. The PT further stated that the residents or the families are usually responsible to pay for the specified medical supplies.

Interview with the ADOC and DOC indicated that when a resident has the assessed needs for using the specified medical supplies for falls prevention and management, staff would recommend the use. The residents or families are usually responsible to purchase them from a vendor. The home would subsidize the cost if the residents or families have the financial needs.

The ADOC and DOC confirmed that the SDM of resident #005 had agreed to purchase the specified medical supplies from a vendor and was charged by the vendor. [s. 91. (4)]

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Issued on this 7th day of February, 2017

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

Original report signed by the inspector.