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
Dec 9, 2020	2020_543561_0014	016175-20, 018724-20, 019007-20, 021726-20, 021743-20	Complaint

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

Long-Term Care Home/Foyer de soins de longue durée

Northridge
496 Postridge Drive Oakville ON L6H 7A2

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

DARIA TRZOS (561), LEAH CURLE (585)

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): November 17, 18, 19, 20, 23, 24, 25, 26, 27, 2020 and December 2, 2020.

The following log numbers were completed during this inspection:
016175-20 - related to multiple care related concerns,
018724-20 - related to multiple care related concerns,
019007-20 - related to falls prevention and pain management,
021726-20 - related to unknown cause of injury and medication incident,
021743-20 - related to unknown cause of injury and medication incident.

A Critical Incident inspection number 2020_543561_0013, was conducted concurrently with this complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (DOC), Physiotherapist (PT), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian, Social Worker, Recreation Manager, Staffing Assistant (Business Office), Nutrition Services Manager, registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the inspector(s): toured the home, observed provision of care, reviewed investigation notes, residents' clinical records, policies and procedures, evaluations of programs, training records and any other relevant documentation related to this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Responsive Behaviours

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

4 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	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 staff provided care to a resident as specified in their plan of care.

On two identified dates in 2020, a resident was observed and the care related to one of the activities of daily living (ADLs) was not provided to them as specified in the plan. PSW and recreation staff were aware of the care and the recreation staff failed to inform a PSW that resident was by themselves trying to complete one of the ADLs independently.

On another day during this inspection, the resident was observed with an interventions for falls not applied. PSW confirmed they were aware the intervention was not in place. RPN confirmed the resident required assistance with ADLs identified and required the intervention for falls that was not applied by the identified PSW.

Failing to ensure that interventions were in place as indicated in the plan of care for this resident put them at increased risk of falls.

Sources: resident's clinical record; observations; interviews with PSWs, recreation staff and RPN. [s. 6. (7)]

2. The licensee has failed to ensure that the outcomes of the care set out in the plan of care were documented.

In 2019, resident's family requested a specific test be completed. The clinical record did not identify whether the test was done. The ADOC confirmed the order for the test was made; however, staff were not able to complete the test based on the resident's condition and the order should have been discontinued.

Sources: resident's clinical record; interview with the ADOC. [s. 6. (9) 2.]

3. The licensee has failed to ensure that a resident was reassessed and their plan of care was reviewed and revised when their care needs changed regarding their mobility status.

A resident had a fall in 2020, and was reassessed by the physiotherapist, who noted the resident's ambulation level changed. Resident's care plan was reviewed for mobility and did not reflect the change in status and prevention of falls. RPN confirmed the status of resident's mobility. The ADOC confirmed the plan of care had not been revised after the resident was assessed by the physiotherapist.

Sources: Resident's care plan; physiotherapist post-fall assessment; interviews with RPN and the ADOC. [s. 6. (10) (b)]

4. The licensee has failed to ensure that resident was reassessed and their plan of care was reviewed and revised when their care needs changed regarding their mobility status.

A Safe Lift and Transfer (SALT) assessment completed on an identified date in 2020, noted the resident's mobility status and the assistance needed. Resident's written care plan was reviewed and did not reflect the change in mobility status. RPN reported the resident required assistance with mobility after experiencing a decline in health. RPN confirmed the resident's care plan had not been reviewed and revised when their care needs changed.

Failing to revise resident's plan of care when their care needs changed increased risk to

the resident as it could have misdirected staff to provide an inadequate level of assistance with ambulation.

Sources: Resident's written care plan; SALT assessment; interview with RPN. [s. 6. (10) (b)]

5. The licensee has failed to ensure that resident's plan of care was reviewed and revised in relation to fall prevention strategies.

Resident was noted as high risk for falls and experienced a fall on an identified date in 2020. The PT completed a PT post-fall assessment and recommended an intervention be used. The clinical record did not show the intervention was implemented, which was confirmed by RPN.

Failing to implement interventions for falls puts resident at risk of greater injury in the event of a future fall.

Sources: resident's clinical record; PT post fall assessment; interview with RPN and other staff. [s. 6. (10) (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 staff provide care to residents as specified in the plan of care; to ensure that the outcomes of the care set out in the plan of care are documented; to ensure that residents are reassessed and their plan of care reviewed and revised when their care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Resident’s clinical record review and the medication incident report identified that on an identified date in 2020, the resident received medications that were prescribed for another resident. RPN was interviewed and stated that they failed to verify the name of the resident prior to administering medications and gave the wrong medications for the resident. The DOC confirmed that the medications for the resident were not administered in accordance with the directions for use specified by the physician.

Not checking the rights of medication administration, in this incident was the 'right resident' leads to medication errors and poses a risk to the health of residents.

Sources: Resident's progress notes; medication incident report; investigation notes; interview with RPN and DOC. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken with respect to resident under the pain program, including assessments, reassessments, interventions and their responses to interventions were documented.

Resident had a history of unresolved pain. During a time period in 2020, staff were required to document weekly pain assessment progress notes, complete 72 hour pain monitoring tools with new or worsening pain, as well as behavioural progress notes and Dementia Observation System (DOS) charting each shift for the identified time period. Documentation of the above listed items was not completed on all shifts.

RPN confirmed documentation was not completed as required. RPN reported assessments of the resident's pain management was present in different areas of the clinical record, which was verified in progress notes, physician's orders, medication administration record (MAR), pain consultations and Behavioural Supports Ontario (BSO) notes. However, failure to complete all documentation as required had the potential to provide an inaccurate assessment of the effectiveness of pain management interventions.

Sources: resident's clinical record (paper and electronic); the home's weekly pain assessment procedure; interview with RPN. [s. 30. (2)]

WN #4: 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 resident received a continence assessment that included identification of causal factors, patterns and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident’s clinical record review identified that they required a continence product change on an identified date in 2020, as indicated on the Incontinence Product Change Request form. PCC was reviewed and indicated that the Continence assessment was not completed when the resident required the product change. RN stated that the process in the home was to complete a 3-Day diary and reassess the resident using the continence assessment in PCC when there is a change in continence or a new product was required. DOC was interviewed and confirmed that the continence assessment was not completed when the resident required product change for this resident.
The home's policy titled "Continence Care - Change in continence", revised January 31, 2020, indicated that the procedure was to initiate a 3-Day Continence Diary with the change in continence status and complete a continence assessment in PCC which will include the evaluation of the 3-Day Continence Diary.

Sources: incontinence product change request form; home's policy "Continence Care - Change in Continence" (CARE2-019-02, January 31, 2020); resident's clinical records; interview with RN and DOC. [s. 51. (2) (a)]

Issued on this 11th day of December, 2020

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

Original report signed by the inspector.