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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2017	2016_298557_0011	028412-16	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

OAK TERRACE
291 MISSISSAGA STREET WEST ORILLIA ON L3V 3B9

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

VALERIE PIMENTEL (557), ROMELA VILLASPIR (653)

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): September 21, 22, 23, 26, 27, 28, 29, 30 and October 3, 2016.

The following critical incidents were inspected:
Log #027289-16 related to an unexpected death.

The following complaint was inspected:
Log #009601-15 related to abuse, plan of care, continence care, medications and nutritional care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), interim Director of Care (iDOC), Registered Dietitian (RD), Nutritional Manager (NM), Environmental Service Manager (ESM), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Worker(s) (PSW), Houskeeping Aide (HKA), Resident(s) and Substitute Decision Maker(s) (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control practice, meal and snack service delivery, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, employee records and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

5 WN(s)
3 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to live in a safe and clean environment.

In September 2016, observations of an identified resident room revealed lingering odors. On another day in September 2016, the inspector observed dry urine under the resident's bed.

An interview with a resident, who resides in the room, stated his/her roommate urinates

all over the room all the time.

Interviews with identified staff members confirmed a strong smell of urine in the identified room and observed dry urine under the room mates bed. An identified staff member also stated the floor was sticky even after thorough cleanings. Both staff confirmed that the room mate does not like to stay in his/her room as he/she does not like the odor and is afraid he/she might slip in the urine found on the floor.

An interview with the EMS confirmed that two weeks earlier the home had implemented cleaning of the identified room three times a day by the HKAs. He/she further indicated this is more than the normal floor cleaning procedures which is one time per day.

Interviews with iDOC and the EMS confirmed the identified room continues to smell of urine and that the room mate will not stay in his/her room and sits as far away as he/she can. The iDOC confirmed that the room mate does not feel safe in his/her room and that each resident has the right to live in a safe and clean environment. [s. 3. (1) 5.]

2. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

In September 2016, on the main floor, inspector #557 observed the electronic Medication Administration Record (eMAR) screen on the medication cart open and unsupervised, with a resident's personal medication administration record visible to the public.

Interview with an identified registered staff stated that he/she had left the screen open and unattended. The next morning the same nurse was working on the main floor. Inspectors #557 and #653 observed the eMAR screen on the medication cart open and unsupervised with a resident's personal medication administration record visible to the public.

Interview with an identified registered staff stated that on both occasions, he/she did not maintain privacy and confidentiality with regards to the residents' personal health information when he/she had left the screen open and unattended on the medication cart.

Interview with the ED stated that the home's expectation was for residents' personal

health information to be kept confidential, and for staff to maintain privacy and confidentiality. [s. 3. (1) 11. 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 the following rights of residents are fully respected and promoted:
1. Every resident has the right to live in a safe and clean environment, and
2. Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, 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 has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) in May 2015, the complainant indicated that a resident had a decline in his/her health status. The resident was admitted to the home in October 2014.

The plan of care identified the following in the progress notes:

-In an identified month in 2014, RD identified to encourage an identified amount of fluid intake identified in millilitres (ml) at each meal and at each snack.
-In an identified month in 2015, the physician decreased the fluid intake to an identified amount of mls per day because the resident's lab work was not normal and discontinued an identified medication.
-One month later, the RD specified the following to ensure adherence to the fluid restriction to give an identified amount of fluid at each meal and at each snack.

Record review of the written care plan dated the first identified month in 2014, for the identified resident revealed the following:
-Focus to maintain weight identified to meet estimated fluid requirements 2750ml fluid/day (25ml/kg) from food and fluids.

The written care plan and kardex did not reflect the above changes to identify the decreased amount of fluids to be consumed at each meal and snack time as directed by the RD.

Staff interviews confirmed they knew the resident was on a fluid restriction but did not know how much he/she was allowed to drink.

An interview with an identified registered staff confirmed he/she would give the resident one or two glasses of water on his/her shift plus what the other identified staff gave the resident during supper and snack time.

An interview with the RD confirmed the resident was ordered a restricted fluid diet and the written care plan and kardex did not instruct the identified staff to give the resident the identified mls of fluid at each meal and at each snack. The RD confirmed that the plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 others who provide direct care to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated: a change of 5 per cent of body weight, or more, over one month.

During stage one of the RQI, a resident triggered related to weight loss.

Review of the resident’s weight summary on Point Click Care (PCC), indicated that his/her weight taken in month A and month B had reduced by greater than 5 per cent over one month. Interview with the RD indicated that the resident had experienced a 9.89 per cent weight loss over the period of one month.

Interview with the Nutritional Manager (NM) stated that residents’ weights were taken by identified staff members during bath days at the beginning of each month. These staff members enter the weights on Point of Care (POC) by the 7th of each month. Registered staff review the weights for significant weight changes and refer to the RD for assessment as required. An identified staff member stated that a referral was not generated for the identified resident related to the significant weight loss in the identified month.

Interview with the RD confirmed that he/she did not receive any referral related to the identified resident related to his/her weight loss in the identified month. The RD further indicated that he/she did not assess the resident for the weight loss as he/she was not aware of it.

Interview with the NM stated that the home’s expectation is that a referel for the identified resident be sent to the RD regarding his/her weight loss. The NM further indicated that an assessment should have been completed as required, related to the identified resident's significant weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 resident with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated when there is a change of 5 per cent of body weight, or more, over one month, to be implemented voluntarily.

WN #4: 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.

Review of Classic Care Pharmacy's policy titled "Administering and Documenting Controlled Substances Policy Number: 4.3" revised on November 2015, under procedure items #1, #2, and #4, indicated:

"1. Locate the Resident's MAR sheet, individual count sheet and controlled substance medication. Each controlled substance medication is individually inspected and verified for correctness against the Resident's MAR sheet, verifying competence, safety and authority.

2. The dose of the controlled substance medication is documented, recording the:

a. Date and time,
b. Administered quantity,
c. Remaining quantity, and
d. Signature of administering person.

4. The controlled substance medication is initialed as administered, on the MAR, in the correct box, immediately after administration and before the next Resident is medicated".

During an observation in September 2016, of an identified resident's identified medication pass on an identified home area, inspector #653 observed an identified registered staff member did not sign the individual count sheet after the administration of narcotic.

Interview with the identified staff member stated that he/she signed the individual count sheets at an approximate time, after he/she had completed the identified medication pass for all residents.

At an approximate time on the same day, inspector #653 and an identified registered staff member reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication. Inspector #653 and the identified registered staff member observed an identified resident's narcotic blister pack the blister pack had an identified number of tablets remaining, while the individual count sheet indicated that the identified resident had a different number of tablets remaining. Review of the eMAR indicated that identified registered staff member administered the narcotic to the resident at two identified times.

Review of the individual count sheet indicated that identified registered staff member did not document the narcotic that was administered at first administration.

Interview with the identified registered staff member stated that he/she administered the identified medication to the resident and had forgotten to sign the individual count sheet.

During an interview, the iDOC acknowledged the discrepancy in the identified resident's individual count sheet and blister pack. He/she further indicated that the home's expectation was for registered staff to sign the individual count sheets immediately after administering the narcotic. [s. 8. (1) (b)]

2. During stage one of the RQI, resident #001 triggered related to weight loss.

Review of the home's policy titled "Height Measurement and Weight Management Index: LTC-G-60" revised June 2014, under assessment items #5 and #6 (i), indicated that:

"5. Residents will be weighed and the weight will be documented by the 7th day of each month. If a weight loss or gain is 2.0 kg or greater from the preceding month, the weight will be confirmed immediately", and "6. The weight record will be reviewed monthly. A nutrition referral to the RD will be completed and the information documented in the interdisciplinary progress notes for the following weight variances: i. Weight loss or gain of greater than or equal to 5% of total body weight over one month"

Review of an identified resident's weight summary in PCC indicated that his/her weight taken in month A and in month B identified the resident had lost an identified amount of weight between the two months. Interview with the RD indicated that the identified resident experienced a weight loss between the two months or a ten per cent weight loss over the period of one month.

Review of the weight entry document for an identified month, did not indicate that the identified resident's weight in that month was confirmed. There was no information to indicate that a re-weigh had been completed.

Interview with an identified registered staff member confirmed that the resident was not referred to the RD when he/she experienced a ten per cent weight loss.

Interview with the RD, stated that if there was a 2 KG difference either weight gain or weight loss from the previous month, staff were supposed to re-weigh the resident immediately. The RD also stated that staff did not re-weigh the identified resident when the resident had a ten per cent weight loss over one month. The RD confirmed that he/she did not receive any referral and that staff should have sent a referral related to the identified resident's weight loss. He/she further indicated that the home's policy was not followed.

Interview with the NM confirmed that the identified resident was not re-weighed in the identified month, when he/she lost weight from the previous month. The NM also stated that a referral should have been sent to the RD when there was a significant weight change, as the policy required. He/she further confirmed that staff did not comply with the home's policy.

Interview with the NM confirmed that the identified resident was not re-weighed in the identified month, when he/she lost more 2 KG's from the previous month. The NM also stated that a referral should have been sent to the RD when there was a significant weight change, as the policy required. He/she further confirmed that staff did not comply with the home's policy. [s. 8. (1) (b)]

WN #5: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

During stage one of the RQI, an identifed resident triggered related to being at low risk for incontinence.

Record review for an identified resident's plan of care , identified the following:
-resident had two Admission/Quarterly Continence Assessments, one completed on admission in month A and the second completed six months later in month B.
- the written care plan was not developed to include a focus, goal or intervention for incontinence of bowels and continence of urine and how the resident remains continent of bladder as resident is bed ridden, and
- the kardex did not have any directions for continence or incontinent care.

An interview with an identified staff member confirmed the resident was incontinent of bowels as he/she did not like to use a bed pan, commode or the toilet.

Interview with an identified registered staff member confirmed the resident was incontinent of bowel and continent of bladder, he/she further confirmed there was no written care plan or kardex developed for the identified resident in reference to his/her bowel and bladder continence.

An interview with the iDOC confirmed the identified resident was incontinent of bowel and that no individualized plan was developed to promote and manage bowel continence based on the assessment and that the plan was not implemented. [s. 51. (2) (b)]

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

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.