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
Aug 11, 2021	2021_792659_0016	008029-21, 008060-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Riverbend Place
650 Coronation Blvd. Cambridge ON N1R 7S6

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

JANETM EVANS (659)

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): July 6, 7, 8, 19, 20, 21, 22 and 23, 2021.

The following intakes were included in this inspection:
Log #008060-21\ Critical Incident System (CIS) report related to alleged resident neglect.
Log #008029-21 \ Complaint related to care concerns and alleged abuse of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), interim Director of Care (DOC), Corporate Nursing manager, Infection Prevention and Control (IPAC) Lead, Registered Nurses (RN)s, Registered Practical Nurses (RPN)s, Personal Support Workers (PSW)s, Personal Support Assistants (PSA), Environmental Services Manager (ESM), Recreation Manager, Maintenance staff, a Housekeeper, former DOC, a Substitute Decision Maker and residents.

Observations were completed of resident dining, Infection Prevention and Control (IPAC) procedures, the home's air temperature, staff to resident interactions and general care and cleanliness of the home. The following records were reviewed including but not limited to: progress notes, care plans, electronic medication administration records (eMAR), electronic Treatment administration records (eTAR), behaviour tracking records, the skin and wound app, the home's investigation notes, reports, surveillance screening records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **6 WN(s)**
- **6 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff documented the provision of care set out in the plans of care for two residents related to altered skin integrity.

A resident's plan of care for altered skin integrity said staff should follow the treatment plan in the resident’s electronic Treatment Administration Record (eTAR). The eTAR said that every shift staff should monitor the area of altered skin integrity and change the dressings as needed. The resident's electronic Treatment Administration Record (eTAR) showed seven blanks in the documentation over a 21 day period.

Staff reviewed PointClickCare (PCC) documentation with inspector #659. They said there was no signoff completed for this.

Sources: eTAR, care plan, PCC skin and wound app, Interviews with ED and staff. [s. 6. (9) 1.]

2. A resident's plan of care for an area of altered skin integrity directed staff to monitor the area and apply a dressing every shift as required (prn) until resolved. The resident's electronic Treatment Administration Record (eTAR) showed seven blanks in the documentation over a 21 day period.

Staff reviewed PCC documentation with inspector #659. They said there was no signoff completed for this.

Failure to document the provision of care for residents related to altered skin integrity, may limit the home's ability to review and update interventions to promote timely wound healing.

Sources: Record review: eTAR, care plan, progress notes, Interviews with ED and staff [s. 6. (9) 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 staff document the provision of care set out in the plans of care for two specified residents related to altered skin integrity, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that temperatures were measured and documented in writing for at least two resident bedrooms in different parts of the home and in every designated cooling area in the home at least once every morning, afternoon between 1200-1700 hours and every evening or night.

Review of the licensee's June 2021 documentation of the humidex heat stress response recording form showed on 25 days there were gaps in the documentation when the temperatures had not been measured and documented on one or more shifts.

The ESM acknowledged air temperatures had not been taken and recorded as required.

Failure to measure and document temperatures required under subsection (2) at least once every morning, once every afternoon between 1200 and 1700 hours, and once every evening or night, could result in the home being unaware of elevated temperatures in the home, which could result in risk of harm to the residents.

Sources: Humidex heat stress response recording form, ESM interview [s. 21. (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 temperatures to be measured under subsection (2) are documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. In addition the licensee will ensure that a record of the measurements documented under subsections (2) and (3) are maintained in the home for at least one year., 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 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.

Staff observed a skin tear on a resident's right arm following care. They reported the altered skin integrity to the RN immediately. The RN said they observed the wound at that time, but did not document this assessment.

A wound assessment was not immediately documented for the resident's area of altered skin integrity. A registered staff member working a different shift completed the assessment after the resident's altered skin integrity was brought to their attention.

The home's procedure for new wounds said once an area of skin impairment was reported or identified, the nurse would complete an assessment using the home's Point Click Care (PCC) Skin and Wound Care Application (app).

Failure to document the assessment of the resident's wound could have resulted in the wound worsening without staff being aware.

Sources: Resident's progress notes, procedure for skin and wounds, Skin Impairment/New Wound Assessment, CARE12-010.02 dated Mar 1, 2021. Interviews with staff. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that equipment was readily available at the home to meet the nursing needs of a resident. Specifically blood pressure equipment was not readily available.

A resident was observed to have changes in their health status.

There were no vital signs recorded for the resident as part of their assessment, with the exception of the resident's blood glucose level.

Staff said they were unable to locate a blood pressure cuff that was the appropriate size for the resident at the time of this incident, so they did not take a blood pressure as part of their assessment.

The ED acknowledged the equipment had not been readily available at the the time of the incident.

Failure to ensure blood pressure equipment was readily available to monitor a resident's vital signs may place residents at risk, as staff would be unable to monitor the resident's blood pressure and provide timely interventions if required.

Sources: Record reviews - weights and vitals, progress notes, Interviews with ED and staff [s. 44.]

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 supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of the residents, to be implemented voluntarily.

WN #5: 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 has failed to ensure that strategies were implemented to respond to a resident demonstrating responsive behaviours.

A resident's plan of care directed staff to leave the resident and reapproach when they demonstrated responsive behaviours. In addition, their plan of care documented the resident's preferred time to wake up in the morning.

Staff woke the resident up prior to their preferred time to get up in the morning, to provide care; resulting in the resident exhibiting physically responsive behaviours. Staff did not leave the resident and reapproach, as per their plan of care. Following care, staff noted the resident had sustained an area of altered skin integrity.

Two staff acknowledged the resident's preferred time for waking up and care in the morning, and also that the resident's plan of care directed them to leave and reapproach the resident when they exhibited responsive behaviours.

The ED said the staff should have used stop and go and reapproach the resident but staff were task focused at the time.

There was harm to the resident when staff did not implement the strategies in resident's plan of care for responding to the resident when they were demonstrating responsive behaviours.

Sources: Care plan, progress notes, home's investigation, interview with ED and staff. [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 to ensure that strategies are implemented to respond to residents demonstrating responsive behaviours, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program related to hand hygiene.

Two staff were observed holding residents hands and assisting four residents with their snacks. The staff members did not clean their hands prior to or after assisting these residents with their snacks.

The home's Routine Practices procedure for infection prevention and control (IPAC) said that hand hygiene was to be performed before and after each contact with residents. Also staff were to perform hand hygiene before preparing, handling, serving or eating foods.

The ED said the expectation was that staff were to sanitize their hands between any resident interaction and before and after care.

Staff failing to cleanse their hands prior to or following interactions with residents or care, placed both staff and residents' at risk for disease transmission.

Sources: Observations, Routine Practices IPC2-010.01, reviewed March 31, 2021, interview with ED and staff. [s. 229. (4)]

2. The licensee failed to implement a hand-hygiene program in accordance with evidence-based practices. Specifically, the home's hand hygiene program did not include hand hygiene procedures for residents in relation to meals and snacks

As per Public Health Ontario, Just Clean Your Hands Long-Term Care Home

Implementation Guide, staff are to encourage and assist residents to perform hand hygiene before and after snacks.

Staff assisted three residents from the dining room without reminding, encouraging or assisting them with hand hygiene following their meal, and provided four residents with snacks and had not reminded, encouraged or assisted them with hand hygiene prior to or following their snacks.

The Regional Nurse Manager #106, acknowledged the home's IPAC policies did not specifically include procedures for resident hand hygiene.

By not including a process for resident hand hygiene in the home's policies and procedures, staff may have been unaware that they were to encourage and/or assist residents to perform hand hygiene before and after meals and snacks. This put staff and residents at risk for disease transmission.

Sources: Routine Practices IPC2-010.01, reviewed March 31, 2021, Preventing the Transmission of Infection IPC2-P10, reviewed March 31, 2021, Hand Hygiene procedure IPC2-010.04, modified March 31, 2021, PHO - JCYH program, interview with Regional Nurse Manager #106 [s. 229. (9)]

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 clean their own hands prior to and following resident interactions and provision of care to residents and encourage or assist residents to clean their hands prior to and following meals and snacks. In addition to this, the licensee should ensure that their hand hygiene program and policy include procedures for resident hand hand hygiene and that staff training will be completed on this policy and procedure, to be implemented voluntarily.

Issued on this 24th day of August, 2021

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

Original report signed by the inspector.