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
May 30, 2017	2017_463616_0005	003916-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

ROSEVIEW MANOR
99 SHUNIAH STREET THUNDER BAY ON P7A 2Z2

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

JENNIFER KOSS (616), KATHERINE BARCA (625)

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): March 20, 21, 22, 23, 24, 2017.

The following intakes were also inspected:

Three Critical Incident System (CIS) reports submitted by the home related to fall with injury, and five CIS reports submitted related to staff to resident abuse.

Two complaints regarding missed baths and wound care lacking.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care, Resident Assessment Instrument Supervisor, Environmental Services Manager, Recreation Manager, Registered Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the Inspector observed the provision of care and services to residents, resident to resident and staff to resident interactions, conducted daily tours of particular resident home areas, reviewed resident health care records, various home policies, procedures, and programs.

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

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

4 WN(s)
1 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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A Critical Incident System (CIS) report was submitted to the Director for an incident of alleged neglect that occurred in August 2016. The report identified that PSW #105 had refused to assist resident #007 as per the resident's usual routine. The report also stated that the resident was not provided with an activity of daily living and that they they attempted to gain the attention of staff, at which time PSW #105 approached the resident and removed them from their current position without providing the activity.

A review of the home's investigation file included witness statements that were consistent with the details submitted in the CIS report. The file also contained a disciplinary letter addressed to PSW #105 which advised that the home had determined that the PSW committed an act of abuse and neglect upon resident #007.

Inspector #625 reviewed the home's policy in place at the time of the incident titled "Resident Non-Abuse – Ontario – LP-C-20-OC", revised date September 2014. The policy defined abuse as written in Ontario Regulation 79/10 and provided examples. The policy also defined neglect as written in Ontario Regulation 79/10 and provided examples. The policy indicated that Revera was committed to providing a safe and supportive environment in which all residents were treated with dignity and respect, that all staff members were to protect the rights of each and every resident entrusted to their care and that any form of abuse by any person interacting with residents, or neglect of residents by staff, would not be tolerated.

During an interview with Inspector #625 on March 24, 2017, the Executive Director (ED) stated that the home's investigation concluded that PSW #105 had abused and neglected resident #007. [s. 20. (1)]

2. A CIS report was submitted to the Director for an incident of staff to resident abuse that occurred in February, 2017. The report identified that PSW #106 was involved in an abusive interaction toward resident #005.

A review of the home's investigation file included witness statements that were consistent with the details submitted in the CIS report. The file also contained a disciplinary letter addressed to PSW #106 which advised them that the home had determined they had committed an act of abuse to resident #005.

A review of the home's policy "Resident Non-Abuse – ADMIN-010.02", effective date August 31, 2016, included attachments provided by the home's Administrator including:

- "Types and Definitions of Abuse or Neglect" (undated); and

- "Non-Abuse - Variances in Legislation - LTC Homes (ON, MB, ALTA, BC)" (undated) which identified that abuse, in relation to a resident was defined as in Ontario Regulation 79/10. The document also cited the Long-Term Care Homes Act s. 20. (2) which indicates that, at a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall provide that abuse and neglect are not to be tolerated and shall provide for a program, that complies with the regulations, for preventing abuse and neglect.

During an interview with Inspector #625 on March 24, 2017, the ED stated that the home's investigation concluded that PSW #106 had abused resident #005. [s. 20. (1)]

3. A CIS report was submitted to the Director for an incident of staff to resident abuse that occurred in February, 2017. The report identified that PSW #111 was involved in an abusive interaction toward resident #004.

A review of the home's investigation file included:

- a disciplinary letter addressed to PSW #111, that read the allegation of abuse made in February, 2017, had been substantiated.

During an interview with Inspector #625 on March 24, 2017, the ED stated that the

home's investigation concluded that PSW #111 had abused resident #004. [s. 20. (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 there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, 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. (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 shall ensure that the provision of the care set out in the plan of care was documented.

Two complaints were received by the Director in February and March, 2017, related to the lack of care for resident #012's altered skin integrity.

During a telephone interview with the complainant in March 2017, they reported to Inspector #616 that resident #012 had an area of altered skin integrity that required treatment and was ordered to be completed with a specific frequency.

The Inspector conducted a review of the resident's health records related to their altered skin integrity. The records identified the current treatment plan for this particular skin alteration. At each treatment, the affected area was to be assessed, and documented at minimum, weekly. The Inspector noted that scheduled treatments were not documented as completed on three occasions.

The Inspector found a record for one of those undocumented treatments where a registered staff member had indicated that they had been unable to complete the treatment and another RPN would be notified to complete. The Inspector found no further documentation in the resident's health record to indicate that this missed treatment had been completed.

The Inspector reviewed assessments and found that the other two scheduled treatments had no documentation to support that the resident's treatments were completed and there had been a worsening in the altered skin integrity.

The Inspector interviewed RPN #107 and RPN #103 who both reported that resident #012's treatments to the area of altered skin integrity were to have been completed with the ordered frequency. RPN #103 reviewed the resident's health record and confirmed the documentation was incomplete for the treatments as ordered on three occasions.

The Inspector conducted a telephone interview with the Director of Care (DOC) on April 4, 2017. They verified that the registered staff were required to document each completed treatment in a specific location of the health record as scheduled. [s. 6. (9) 1.]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Inspector #625 observed resident #001's mobility aide to be soiled with debris, dust, dried liquid and food in various areas on the equipment.

Two days later, the Inspector observed the same debris, dust, dried liquid and food particles on the mobility aide, additionally with an larger piece of debris observed.

A review of resident #001's health care record included the task listed in Point Click Care as "Cleaning Schedule - ON - Mobility Aids". This task had been documented as being completed hours earlier on the day of the Inspector's most recent observations, and had been marked as not done as scheduled the previous week.

During interviews with PSWs #100 and #101 on March 23, 2017, both PSWs stated that mobility aides were scheduled to be cleaned on the night shift and that the scheduled cleaning days were identified in Point of Care (POC). PSW #100 viewed resident #001's mobility aide with the Inspector and acknowledged that it was not clean.

On March 23, 2017, RPN #103 stated that resident #001 was scheduled to have their mobility aide cleaned on a certain day of the week, and that it had been documented as being completed earlier in the day when the Inspector had made their second observations. The RPN attended resident #101's room with the Inspector and acknowledged that the mobility aide had not been cleaned recently and that debris, dust, food particles, liquid, crumbs and larger food particles were present. The RPN stated that the mobility aide had not been cleaned on that particular day as was documented and appeared to not have been cleaned for at least several weeks, if not longer. [s. 15. (2) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Two complaints were received by the Director in February and March, 2017, related to missed baths/showers for resident #012.

During a telephone interview with the complainant in March 2017, they reported to Inspector #616 that resident #012 required baths/showers related to a medical condition and had not received some of their scheduled baths/showers throughout a specific period of time.

Inspector #616 reviewed resident #012's plan of care related to bathing. They were scheduled for a specific form of bathing on particular days of the week related to their current medical condition with specific assistance from staff.

The Inspector reviewed the home's bath/shower reports for an approximate three month period. The following weeks were identified when the resident had not received their two weekly baths/showers as per their plan of care,during:

- one particular week, on one occasion "Activity did not occur" was documented but did not specify why.

- another week, "Activity did not occur" was documented, and that the resident had not declined.

The Inspector completed a record review for the two dates where the "Activity did not occur". On the first date, it was documented that resident #012's bath/shower was

missed. There was no indication that the resident's missed bath was made up. The Inspector reviewed a Registered Staff Verification Checklist for the second date where resident #012 had been identified as not having received their scheduled bath/shower. There were no further records found to verify that resident #012 had received this missed bath/shower.

The home’s document “Missed Bath Reporting Process” was reviewed by the Inspector. The Inspector found that for two or less missed baths (showers) on a shift, the PSWs were to complete the missed bath during the next day, they were to ensure that all baths were completed, and documented in POC. The DOC or designate was to follow up with the completion process at the next daily round.

The Inspector interviewed PSW #109 on March 23, 2017, and PSWs #110 and #108 on March 24, 2017, related to the documentation of baths/showers. They all stated the baths were documented by PSWs in the resident’s POC. Regarding the documented “Activity did not occur” on the two occasions in particular, the three PSWs reported separately that when a resident did not receive their scheduled bath/shower due to staffing issues, they documented this statement and specified that the resident did not decline. During an interview with RPN # 103, they stated that the home had a process for missed baths, which was consistent with the home’s "Missed Bath Reporting Process".

The DOC verified to the Inspector that resident #012 had not been provided their two weekly showers/baths as scheduled on the two identified dates, and that the home’s process for providing these missed baths/showers had not been followed for resident #012. [s. 33. (1)]

Issued on this 1st day of June, 2017

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

Original report signed by the inspector.