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
Jul 5, 2016	2016_337581_0008	013848-16, 017501-16	Critical Incident System

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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 13, 14, 15, 2016.

Critical Incident System (CIS), log #017501-16 related to prevention of abuse and log #013848-16 related to falls prevention were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.
The inspector observed the provision of care and services, reviewed relevant documents, including but not limited to: policies and procedures, meeting minutes, clinical health records, training records and staffing schedules.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **8 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	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 failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

Review of the current written plan of care for resident #002 indicated under the bladder and bowel incontinence focus that they required continence care products and for staff to see the prevail list for details. Review of the Medical Mart, prevail continence worksheet indicated they required "ONP" which was a liner. Interview with PSW #103 and PSW #107 stated they did not know what "ONP" meant and revealed that resident #002 wore a pull up product for continence care. Interview with PSW #106 stated they wore their own underwear with a liner. Resident #002 was observed on June 14 and 15, 2016, wearing a pull up product and stated they preferred the pull up as it was more absorbant. Review of the Resident Assessment Protocol (RAP) assessment in May 2016, identified

they wore a liner. Interview with registered staff #100 stated resident #002 wore a liner and a logo was to be posted on the inside of the resident's closet to identify what continence product they needed but confirmed it was not there. They indicated that PSW staff were to follow the logo to ensure the correct continence product was used. Registered staff #100 confirmed that there was no clear direction to staff related to what continence product was required. [s. 6. (1) (c)]

2. The licensee failed to ensure that staff and others involved in different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

Review of the Minimum Data Set (MDS) assessment for resident #002 completed in May 2016, indicated they did not exhibit any behavioural symptoms. Review of the Point of Care (POC) documentation during the observation period between May 17 and May 24, 2016, identified that they exhibited one responsive behaviour. Interview with PSW #108 and PSW #106 stated that resident #002 does have responsive behaviours as they want to be independent and they do not want assistance. Interview with registered staff #100 stated that resident #002 displayed responsive behaviours and the MDS and POC assessments were not consistent with each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #001 fell on an identified day in April 2016, sustained an injury, was admitted to hospital and was discharged back to the home several days later in April 2016, with a significant change. Review of the MDS assessment in April 2016, identified that the resident was not reassessed as a significant change in status when they returned from hospital. Review of the plan of care revealed the resident was not reassessed and the written plan of care was not reviewed and revised, when their care needs changed until an identified day in May 2016. Interview with registered staff #100 stated that resident #001 had a significant change in status and confirmed that the resident was not reassessed and the written plan of care was not revised when the resident's care needs changed related to an injury and a significant change. [s. 6. (10) (b)]

4. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the care set out in the plan had not been effective.

Review of resident #002's plan of care indicated they required an intervention to prevent falls as they were at risk of falling. Interview with the resident and PSW #106 identified they did not want the intervention and would remove it. Interview with registered staff #100 confirmed that the resident removed the intervention to prevent falls as they did not want to use it and the intervention was not effective for preventing falls. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other 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. 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The home's policy, Fall Intervention Risk Management (FIRM) Program, LTC-E-60, revised March 2014, indicated if a fall was not witnessed or the resident had hit their head, a neurological assessment would be initiated (LTC-E-70-Head Injury Routine) and the resident would be monitored for 72 hours.

Resident #001 sustained an unwitnessed fall on an identified day April, 2016. Review of the plan of care identified that the head injury routine (HIR) was not initiated. Interview with the registered staff #100 confirmed that the resident had an unwitnessed fall and the HIR was not completed as required by the home's policy.

B. The home's policy, Admission, Transfers, Discharges and Death, LTC-B-80, revised November 2015, required that the nurse on the admitting shift would complete an assessment and document on the interdisciplinary progress notes.

Resident #001 was discharged from hospital on an identified day in April 2016, after being admitted with an injury. Review of the plan of care revealed that no assessment was completed or documented in the progress notes when they were readmitted. Interview with registered staff #100 stated that when a resident was readmitted to the home post hospitalization, the registered staff were to complete the following assessments in Point Click Care (PCC) including but not limited to, Head to Toe, Fall Risk, Safe and Lift Transfer, diary for bowel and bladder and pain monitoring sheets as per guidelines on paper. Registered staff #100 confirmed that none of the assessments were completed when resident #001 returned from hospital as per the home's policy. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances for the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #001 fell on an identified day in April 2016 and sustained an injury. Review of the plan of care indicated that a post falls assessment was not completed for over twenty-four hours and at that time the resident was admitted to hospital. The home's policy, Fall Intervention Risk Management (FIRM) Program, LTC-E-60, revised March 2014, required that upon discovering a resident who had fallen, the nurse would complete an immediate assessment of the resident and implement appropriate follow-up actions. Interview with the ADOC confirmed that the registered nurse did not complete the post fall assessment on the day that resident #001 fell and sustained an injury. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following were developed to meet the needs of the residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that would result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

Review of the MDS assessment in May 2016 and the written plan of care for resident #002 did not identify they exhibited any behavioural symptoms. Review of the Point of Care documentation from May 17 to June 14, 2016, indicated that they had exhibited responsive behaviours fourteen times on both day and evening shifts. Interview with PSW #112 and PSW #107 revealed resident #002 constantly informed staff that they did not require assistance, wanted to be independent with their care and they would have an increase in responsive behaviours if staff persisted on helping them. Both PSW's stated the best approach was to re-approach or to stand close to them and only give assistance as needed or if at risk of falling as their responsive behaviours would increase if confronted. Interview with registered staff #100 confirmed that resident #002 was not assessed as having responsive behaviours and the written plan of care did not provide interventions related to approaches to care or behavioural triggers that could result in responsive behaviours. [s. 53. (1) 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 the following are developed to meet the needs of the residents with responsive behaviours: written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that would result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in accordance with O. Reg 219, in abuse recognition and prevention and behavioural management.

A. Information provided by the home indicated that PSW #112 last received annual training on, "Acknowledgement and Understanding of Obligations Related to Resident Non-Abuse Policy" on March 31, 2014.
B. Interview with the Executive Director confirmed that the home did not have any documented records of when PSW #112 last received annual training on "Dementia Care" or responsive behaviours.
C. Interview with PSW #112 stated they had not received annual training in abuse recognition or responsive behaviours in several years. [s. 76. (7)]

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in accordance with O. Reg 219, in abuse recognition and prevention and behavioural management, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received training annually in accordance with O. Reg 79/10, s. 221 (1) 1, 3, 4, in the areas of falls prevention and management, continence care and bowel management and pain management.

A. Information provided by the home indicated that agency registered nursing staff #120 did not receive training in falls prevention and management prior to working in the home and this was confirmed by the ADOC.

B. Information provided by the home identified that agency registered nursing staff #121 did not receive training in falls prevention and management, continence care and bowel management and pain management prior to working in the home and this was confirmed by the ADOC. [s. 221. (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 failed to ensure that all staff who provide direct care to residents receive training annually in accordance with O. Reg 79/10, s. 221 (1) 1, 3, 4, in the area of falls prevention and management, continence care and bowel management and pain management, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff, upon any return of the resident from hospital.

Resident #001 fell on an identified day April 2016, sustained an injury and was admitted to hospital. Review of the plan of care indicated that the resident had altered skin integrity prior to being admitted to hospital. Interview with registered staff #100 confirmed that when the resident returned from hospital on an identified day in April 2016, a skin assessment was not completed. [s. 50. (2) (a) (ii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Resident #001 fell on an identified day in April 2016, sustained an injury and was admitted to hospital. Review of the discharge orders indicated they were prescribed pain medication and had a significant change in status. Review of the plan of care identified that a pain assessment was not completed when readmitted to the home on an identified day in April 2016 and this was confirmed by registered staff #100. [s. 52. (2)]

Issued on this 14th day of July, 2016

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

Original report signed by the inspector.