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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 2, 2018	2018_718604_0011	020877-18	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

Thorntonview
186 Thornton Road South OSHAWA ON L1J 5Y2

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

SHIHANA RUMZI (604)

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): August 22, 23, 24, and 27, 2018.

The following intakes were inspected:
Complaint inspection intake #020877-18, related to a fall

Critical Incident System Report (CIS) intake# 020682-18, related to falls.

During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Care (DOC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector made observations of staff and resident interactions, provision of care, conducted reviews of health records, and critical incident log, staff training records, reviewed relevant policies and procedures, and conducted staff interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

The licensee had failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision Maker (SDM) of the resident with authority to give that consent.

The home submitted a Critical Incident System (CIS) report on an identified date which indicated an incident which occurred caused injury to a resident for which the resident was taken to hospital which resulted in a significant change in the resident's health status which resulted in an identified injury to the resident. The CIS was later amended on an identified date, which indicated that the home conducted an investigation and had

reviewed the home's camera footage and discovered that resident #002 was walking with resident #003 in an identified location of the home and the residents where often seen together. The two residents decided to go into an identified location of the home and opened an identified door and got distracted by a staff member in the hall. Resident #003 appeared they should not enter the identified area of the home and nudges resident #002 who was attempting to enter an identified area of the home and resident #002 fell to the ground.

The Ministry of Health and Long Term Care (MOHLTC) ACTIONline received a complaint on an identified date, from resident #002's Substitute Decision Maker (SDM). The SDM had indicated that the resident had an unwitnessed fall and sustained an identified injury. The complainant also indicated that the home would not let them review the video footage of the incident as it was against the home's policy.

Observations of resident #002 was carried out on multiple occasions and on identified dates and times and the resident was identified to be utilizing an identified device.

Inspector #604 screened resident #002 and the resident was unable to carry out an interview.

A review of the resident #002's written plan of care with a last care plan for an identified date indicated in a focus the residents mobility status and the identified device required.

A review of resident #002's progress notes was carried out for an identified period of time and there was no evidence in the progress notes of the SDM of resident #002 being informed or consenting to the use of the identified device.

A review of resident #002's health records was carried out and Inspector #604 was unable to find evidence in the health records of a signed consent for the use of the identified device for resident #002.

Interviews were conducted with Registered Practical Nurse (RPN) #105 and #106, who stated if an identified device was to be used the family was to consent prior to utilizing the identified device. The RPN's stated resident #002 utilized an identified device due to a change in health status. The RPN's reviewed resident #002's health records, and acknowledged that there was no SDM consent signed for resident #002 to utilize an identified device.

An interview was conducted with the home's Director of Care (DOC) who was informed of Inspector #604's review of resident #002's health records and was informed that they were unable to find evidence that resident #002 had consent from the SDM for the use of an identified device. The DOC acknowledged that the home requires consent from the SDM for the use of an identified device and stated resident #002 did not have a consent for the use of the identified device.

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 ensure that:
-the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was included in a resident's plan of care only if the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision Maker (SDM) of the resident with authority to give that consent, to be implemented voluntarily.

Issued on this 3rd day of October, 2018

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

Original report signed by the inspector.