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
Feb 26, 2020	2020_523461_0001	017745-19	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

CRISTINA MONTOYA (461)

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): February 4, 5, 6, and 7, 2020

During this inspection the following intake was inspected:

A complaint intake related to continence care.

PLEASE NOTE: A Written Notification related to LTCHA, 2007, c.8, s. 8(1)(b), identified in a concurrent inspection #2020_807644_0002 was issued in this report.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and family members.

The inspector also reviewed resident health care records, the licensee's relevant policies and procedures, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care is provided to resident as specified in the plan, specifically related to continence care.

The Director received a complaint regarding the staff not providing continence care to resident #004. During a review of resident #004's health records, inspector #461 identified a specific intervention for continence care in the resident's written plan of care, which was not being provided by the staff.

On an identified date, inspector #461 observed that staff did not provide resident #004 with the identified intervention related to continence care as specified in the written plan of care.

During separate interviews with PSW #103, #107, #108 and RPN #116, by inspector #461, they indicated that resident was offered continence care at minimum two times every shift, but they were unaware that resident was on a continence care program that required care for specific times during the day.

During an interview, the RAI coordinator indicated that they added the intervention related to continence care on an identified date, but they forgot to add a task on the point of care (POC) for the PSWs' reference to implement the intervention. Therefore, the registered staff and the direct care staff did not implement the identified intervention for several months because the intervention was not included on POC.

During an interview with the Associate Director of Care (ADOC), they acknowledged that the registered staff should have made the PSWs aware of resident #004's interventions for continence care in order to implement the intervention as set out in the resident's plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004 as specified in the plan, specifically related to continence care. [s. 6. (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 the care set out in the plan of care is provided to the residents as specified in the plan, 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 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 it is complied with.

According to O.Reg 79/10 r. 51. (2) (a) the licensee shall ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

Specifically, staff did not comply with the licensee's procedure to conduct a complete continence assessment on admission as per "Continence Care – Move-In" policy, which was part of the licensee's continence care program.

The Director received a complaint regarding the staff not providing continence care to resident #004. A non-compliance was found related resident #004 not receiving the care

set out for the plan of care for continence care. Therefore, an increase in sample size was conducted, which included resident #005.

During a review of resident #004's health records, inspector #461 identified specific interventions for continence care in the resident's written plan of care, which were not being provided by the staff. The assessment did not include to offer the resident an identified continence care intervention.

Review of resident #005's health records revealed that the RAI coordinator had opened a continence assessment on admission in Point Click Care (PCC) on an identified date, but the registered staff did not complete it. Additionally, resident's progress notes on an identified date, revealed that a continence assessment was not completed when the resident's continence care needs changed.

In an interview with the RAI coordinator, they acknowledged that resident #004's identified assessment was incomplete and resident #005's identified admission assessment was not completed. The RAI coordinator further indicated that RPN #102 was assigned to complete the identified assessment, but it was not finalized.

During an interview with the ADOC, who was also the lead of the continence program in the home, identified that when a resident was admitted to the home, the PSWs were expected to complete a continence care diary, which was documented on paper or POC and passed the information onto the registered staff in the unit. The registered staff was responsible of completing the specific assessment on PCC based on the diary. The continence assessments were expected to be completed on admission and whenever there was a change in a resident's continence status. The ADOC acknowledged that the home's policy for Continence Care was not complied with.

The licensee failed to ensure that its Continence Care program was complied with, specifically related to residents #004 and #005, who did not have a complete identified assessment done on admission.

2. The license failed to ensure that 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 it is complied with.

According to O.Reg 79/10 r. 49. (2) the licensee shall ensure that when the resident has

fallen, the resident has been assessed and a post-fall assessment has been conducted.

Specifically, staff did not comply with the licensee's strategy to conduct a Post Fall Assessment immediately following the fall as per "Falls Prevention and Injury Reduction" policy, which is part of the licensee's falls prevention and management program.

On an identified date, a Critical Incident System (CIS) report was submitted to the Director related to an incident of a fall that resulted in injury.

Review of CIS report revealed that on an identified date, Dietary Aide #101 reported to RPN #104 that resident #001 had been found on the floor complaining of pain on an identified body part and was transferred to hospital for further assessment that resulted in an identified injury.

Review of resident #001's assessment and written plan of care completed on an identified date, revealed the resident had no physical impairments. The resident required minimal support for transfers, using a mobility aid and supervision when walking.

Review of resident's health record indicated that resident #001 was identified to be at risk for falls. The progress notes on an identified date revealed that resident was found on the floor by a dietary staff and was complaining of pain on an identified body part. Resident was sent to hospital for further assessment and upon return from hospital, the physician identified that resident had sustained an injury from the fall.

Further review of resident #001's health records revealed no documentation that a post fall assessment was completed for the fall that occurred on the identified date.

In an interview, RPN #104 confirmed that they worked on the identified date the fall occurred. The RPN stated that after a resident had a fall, an incident report in the home's risk management and a post fall assessment were to be completed. RPN #104 further stated they did not realize they did not complete the post fall assessment when informed by inspector #644 that there was no documentation for a post fall assessment for the above incident.

In separate interviews, RPN #102, RN #109 and RN #112 indicated that after a resident had fallen, the staff was required to complete a post fall assessment. They further indicated this was not done for resident #001's fall for the identified incident.

Interview with the home’s ADOC identified that if a resident sustained a fall, it would require the staff to complete a post fall assessment. The ADOC stated if the staff completed the incident report in the home’s risk management and the post fall assessment was not triggered, the home’s expectation would require the staff to complete the post fall assessment in PCC under the resident’s assessment tab. The ADOC acknowledged that the home's policy for Falls Prevention and Injury Reduction Program was not complied with.

The licensee failed to ensure that its Falls Prevention program was complied with, specifically related to resident #001, who sustained a fall on an identified date, there was no documentation to support that a post fall assessment had been completed. [s. 8. (1) (b)]

Issued on this 5th day of March, 2020

[redacted]

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

Original report signed by the inspector.