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
Jun 9, 2021	2021_890758_0011	009216-20, 012286-20, 014610-20, 018541-20, 020927-20	Critical Incident System

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

Main Street Terrace
77 Main Street Toronto ON M4E 2V6

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

DANIELA LUPU (758), JANET GROUX (606)

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): May 17-20, 25-28, and 31, 2021.

The following intakes were completed in this Critical Incident (CI) inspection:

Log #014610-20, related to abuse;
Log #009216-20, Log #12286-20, Log #018541-20, and Log #020927-20, related to falls prevention and management.

PLEASE NOTE: Written Notifications (WN) and Voluntary Plans of Correction (VPC) related to O. Reg.79/10, s. 50 (2) (b) (i) and s. 30 (2), identified in a concurrent inspection #2021_890758_0012, Log #022805-20, were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Director of Care (ADOC), Infection Prevention and Control (IPAC) Lead, Behavioural Support Ontario (BSO) Lead, Physiotherapist (PT), Skin and Wound Care Nurse, Environmental Services Manager (ESM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, residents and their Substitute Decision Makers (SDM).

The inspector(s) observed staff to resident interactions, infection prevention and control practices and safety conditions of the home. They also reviewed clinical records, the home's policies and procedures, and documents pertinent to the inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

4 WN(s)
4 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 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 has failed to ensure that safety checks for three residents were documented as specified in their falls management plans of care.

Residents #003, #004, and #005 had falls in 2020 resulting in their transfers to the hospital and significant change in their condition.

These residents' plans of care identified them at risk for falling before and after they fell in 2020. One of the falls prevention interventions directed staff to perform safety checks at specified times during each shift and to document them in the residents' Point of Care (POC).

Review of residents #003's, #004's, and #005's documentation of the safety checks over a specified period of time, showed that on multiple occasions the documentation was missing.

Sources: resident #003's, #004's, and #005's care plans, POC documentation, and interviews with ADOC #103. [s. 30. (2)]

2. The licensee has failed to ensure that interventions related to skin and wound care for two residents were documented.

A. Resident #002 was identified as being at risk for impaired skin integrity and their plan of care included specific interventions to mitigate the risk for skin breakdown. Staff were to document in POC these interventions at specified times during each shift.

Over an identified period of time, resident #002's skin and wound care documentation

showed multiple occasions when the documentation was missing or was not completed as required.

B. Resident #006 was at risk for impaired skin integrity and their plan of care directed staff to provide specific interventions to prevent skin breakdown. On an identified date, the resident had a significant change in their condition and had areas of altered skin integrity for which a new intervention was implemented in their plan of care. Staff were to document in POC the resident's skin care interventions at specified times during each shift.

The resident's skin care documentation over that specific period of time showed that on multiple occasions the documentation was missing or was not completed as required. Further review of the documentation after the significant change in resident #006's condition also showed missing documentation or documentation not completed as indicated in their plan of care.

Failing to ensure that residents #002's and #006's interventions related to skin and wound care were documented as indicated in their plan of care, increased the risk that the effectiveness of these interventions could not be evaluated and could have resulted in harm to the residents.

Sources: residents #002's and #006's care plans, progress notes, POC documentation, and interview with ADOC #103. [s. 30. (2)]

3. The licensee has failed to ensure that interventions related to continence care and bowel management for three residents were documented.

A. Resident #001's continence care routine included specific times for the provision of their continence care. Staff were to document the continence care in POC at specified times during each shift.

Over an identified period of time, resident #001's documentation for the continence task showed multiple occasions when the documentation was missing or was not completed as specified in their continence care routine.

Sources: resident #001's care plan, POC documentation, and interview with ADOC #103.

B. Resident #002 had an individualized continence care program. The resident's

continence care routine included specific times for the provision of their continence care. Staff were to document the continence care in POC at specified times during each shift.

Over an identified period of time, resident #002's continence care task documentation showed that on multiple occasions the documentation was missing or was not completed as indicated in their continence care program.

Sources: resident #002's care plan, POC documentation, and interview with ADOC #103.

C. Resident #006 had an individualized continence care program. Their continence care routine included specific times for the provision of their continence care and staff were to document in POC at specified times during each shift.

Over an identified period of time, resident #006 had a significant change in their condition and developed altered skin integrity. The resident's continence care documentation over that period of time showed that on multiple occasions the documentation was missing or was not completed as indicated in their continence care program. Further review of the documentation after the significant change in resident #006's condition also showed missing documentation or documentation not completed as required.

Sources: resident #006's care plan, POC documentation, and interview with ADOC #103. [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 #2: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that two residents' altered skin integrity was assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

A. Resident #002 was identified to have an area of altered skin integrity. The resident was assessed by the physician and a treatment was prescribed to be administered until the affected area healed. No skin and wound assessments were completed for the affected area.

B. Resident #006 was identified to have areas of altered skin integrity. The resident was assessed by the physician and a treatment was prescribed to be administered for a specified time. No skin and wound assessments were completed for one of the affected areas.

Skin and Wound Care Nurse stated that when any skin impairment was reported or identified, skin and wound assessments should have been completed in Point Click Care (PCC).

Failing to ensure residents #002 and #006 received a skin assessment by a member of the registered nursing staff could have resulted in further harm to the residents.

Sources: residents #002's and #006's clinical records, interviews with Skin and Wound Care Nurse and other staff. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #3: 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 developed and implemented to respond to resident #001's responsive behaviours.

Residents #001 and #002 had limited cognitive and decision making abilities. Resident #001 had a history of identified responsive behaviours towards resident #002.

Resident #001 was observed displaying the identified responsive behaviours towards resident #002. Resident #001's responsive behaviours were unpredictable and required monitoring and redirection from staff. Their plan of care did not include interventions to address the resident's responsive behaviours until after the incident involving resident #002.

The home's BSO Lead stated that interventions to address resident #001's identified responsive behaviours should have been in place to mitigate the risk for further incidents.

Failing to ensure that strategies were developed and implemented to respond to resident #001's identified responsive behaviours increased the risk of further incidents and put the residents at risk of harm.

Sources: critical incident report, resident #001's and #002's clinical records and interviews with BSO Lead, ADOC #105 and other staff. [s. 53. (4) (b)]

2. The licensee failed to ensure that actions taken to meet resident #001's responsive

behaviours needs were documented.

Resident #001 had a history of responsive behaviours and their plan of care included safety checks at a specified interval.

Resident #001 was observed displaying an identified responsive behaviour towards resident #002 and the safety checks task was updated to include monitoring of their behaviour. A Dementia Observation System (DOS) and a specific monitoring tool were also initiated to monitor the resident's responsive behaviours.

The resident's chart did not include a record of the DOS and the specific monitoring tool and these tools could not be located at the time of the inspection. Review of the safety checks documentation for a month period, revealed multiple occasions when the documentation was missing and 53 per cent of the safety check entries were not documented at the scheduled time.

ADOC #105 stated that the safety checks should have been documented at the scheduled time as indicated in the resident's plan of care.

Failing to ensure that the interventions to manage resident #001's responsive behaviours and their responses to the interventions were documented, increased the likelihood that the effectiveness of the interventions could not be evaluated and could have resulted in harm to the resident.

Sources: resident #001’s clinical records, the home's BSO binder, and interviews with ADOC #105 and other staff. [s. 53. (4) (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, for each resident demonstrating responsive behaviours strategies are developed and implemented to respond to these behaviours, where possible; and 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, to be implemented voluntarily.

WN #4: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the home's IPAC program, in relation to appropriate usage of Personal Protective Equipment (PPE).

On March 17, 2020, the Premier of Ontario and Cabinet issued a COVID-19 emergency in the Province of Ontario under the Emergency Management and Civil Protection Act. On March 22 and 30, 2020, Directive #3 was issued and revised on May 21, 2021, to all Long-Term Care Homes (LTC Homes) under the Long-Term Care Homes Act (LTCHA), 2007, under section 77.7 of the Health Protection and Promotion Act (HPPA) R.S.O. 1990, c H.7. by the Chief Medical Officer of Health (CMOH) of Ontario. The CMOH advised that residents of LTC Homes were at immediate and increased risk of COVID-19 and an urgent requirement was made for all LTC Homes to implement measures to protect all residents and staff.

At the time of this inspection, nine residents were on droplet and contact precautions.

Droplet and Contact precautions signage was posted on the door of these residents' rooms. The signage directed staff to wear a mask and eye protection before entering these rooms and being in contact with these residents.

Donning and Doffing Personal of Protective Equipment (PPE) signage was also posted on the door of these residents' rooms and directed staff to disinfect or discard their masks and eye protection prior to exiting these residents' rooms.

On three separate occasions, three staff members were observed providing direct care to and being within two meters of residents on droplet and contact precautions, while in their rooms. Two of these staff did not discard their mask and one of them did not disinfect their eye protection and discard their mask prior to exiting these residents' rooms.

The home's IPAC Lead stated staff should have discarded their masks and disinfected their eye protection prior to exiting these residents' rooms to prevent the potential spread of infectious disease throughout the home.

Failing to ensure staff doffed and disinfected their PPE when required, increased the risk of transmission of infectious disease to residents, staff and visitors throughout the home.

Sources: observations, the home's IPAC policy, Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, (November 2012); Directive #3 (2021), IPAC Recommendations for Use of PPE for Care of individuals with Suspect or Confirmed COVID-19 (January 2021), Droplet and Contact Precautions signage, signage for Applying and Removing PPE and interviews with IPAC Lead and other staff. [s. 229. (4)]

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 participate in the implementation of the home's Infection Prevention and Control (IPAC) program, to be implemented voluntarily.

Issued on this 10th day of June, 2021

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

Original report signed by the inspector.