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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 7, 2019	2018_650565_0019	022359-17, 028084-17, 029647-17, 001230-18, 021943-18, 022542-18, 028733-18	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

Westside
1145 Albion Road ETOBICOKE ON M9V 4J7

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

MATTHEW CHIU (565), JOANNA WHITE (727), PRAVEENA SITTAMPALAM (699)

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): November 13, 14, 15, 16, 19, 20, 21, 22, 26, 27, 28, 29, 30, December 3, 4, 5, 6, and 7, 2018.

During the course of the inspection, the following Follow-Up intake logs were inspected concurrently with this inspection:
- #001230-18 related to safe and secure home, and
- #022542-18 related to admission and discharge.

During the course of the inspection, the following Critical Incident (CI) intake logs were inspected:
- #022359-17 related to resident care,
- #028084-17 related to prevention of abuse,
- #029647-17, #021943-18 related to the incidents causing residents injuries, and
- #028733-18 related to a specified medical condition of a resident.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Staff Educator (SE), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Dietary Aide (DA), Recreation Aide (RA), Housekeeping Staff (HS), Maintenance Services Manager (MSM), Agency Rehabilitation Staff (ARS), Physiotherapy Aide (PTA), Pharmacy Consultant (PC), Coroner, residents, and family members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staff training records, menus, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 148. (2)	CO #001	2018_751649_0014	565
O.Reg 79/10 s. 15. (1)	CO #001	2017_659189_0025	565

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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed resident #025 complained of a specified health condition on an identified date. The physician was informed, and they ordered an examination. On an identified date, examination revealed a specified diagnosis. On the next day, resident #025 was transferred to the hospital for a specified treatment and returned to the home on the same day.

Review of resident #025's identified Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessments and the plan of care revealed the resident had mild cognitive and physical impairments. The resident was able to perform the identified cognitive and physical functioning. The plan of care further stated the resident was at risk for falls and had a specified falls prevention intervention implemented.

Review of the progress notes and the home's records revealed that on an identified date, an identified visitor reported the resident's above mentioned complaint to staff. The home's records further revealed that on an identified date, PSW #115 left an identified object in resident #025's room which created a safety risk for resident #025.

Interview with resident #025 stated they hit an identified body part on the identified object in their room. They did not remember when it was, but they told the above mentioned visitor about their complaint later.

Interviews with two identified visitors revealed that staff sometimes put the above mentioned object near resident #025's bed. One of the identified visitors further stated on an identified date, they reported to staff about resident #025's specified complaint. The resident did not tell the identified visitor what happened until a few days later and stated that they hit the identified object. The identified visitor thought that resident #025 hit themselves on the object a few days before they complained to them on the identified date.

Interviews with PSW #113 and RPN #119 acknowledged the specified falls prevention intervention for resident #025's safety, and this includes that the above mentioned identified object should not be placed in resident #025's area in the room.

Interview with PSW #115 indicated on an identified date and time period, PSW #115 and their partner assisted resident #025's roommate with the specified care. Due to a specified reason, they put the above mentioned identified object in resident #025's area

in the room. PSW #115 confirmed that after the specified care, they forgot to remove the object from the area and left the room.

Interview with the DOC indicated resident #025's plan of care directed staff to implement the specified falls prevention intervention. The DOC further stated the above mentioned object should have been removed from resident #025's environment according to the intervention. The DOC confirmed the care set out in resident #025's falls prevention plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

2. The MOHLTC received a CIS report related to a specified medical status for resident #036 on an identified date.

Record review of resident #036's progress notes showed that on an identified date, resident #036 complained of a specified health condition. The resident was assessed by the physician who made a specified recommendation, and resident #036 refused. Review of the resident's clinical health records showed that on the identified date, the physician wrote another specified order, and it was signed off by two registered staff members.

Record review of the electronic medication administration record (eMAR) did not show the specified physician's order. Further review of resident #036's progress notes showed no documentation that the specified order was administered to the resident on different shifts on three identified dates following the order.

In an interview with RPN #140, they could not recall if they administered the specified physician's order for the resident on one of the above mentioned shifts. RPN #140 further stated they would have administered the specified order if it was reflected on the eMAR. They stated that the nurse who signs off the physician's order must put it in the eMAR as that is the process to ensure oncoming staff follow the physician's order.

In an interview with the DOC, they stated the physician's orders are part of the resident's plan of care, however it also must be entered on the eMAR so that it would not be missed. The DOC stated it should be documented in Point Click Care (PCC). The DOC acknowledged that for resident #036, their plan of care was not followed as specified in the plan. [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 resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and not neglected by the licensee or staff.

For the purpose of the Act and the Ontario Regulation 79/10, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The MOHLTC received a CIS report related to a specified medical status for resident #036 on an identified date.

Record review showed resident #036 had identified diagnoses. The specified plan of treatment for resident #036 indicated they wanted a specified approach to treatment in the event of a specified medical condition.

Record review of resident #036's progress notes showed that on an identified date, resident #036 complained of a specified health condition. The resident was assessed by the physician who made a specified recommendation, and resident #036 refused. Review of the resident's clinical health records showed that on the identified date, the

physician wrote another specified order, and it was signed off by two registered staff members.

Record review of the eMAR did not show the specified physician's order. Further review of resident #036's progress notes showed no documentation that the specified order was administered to the resident on different shifts on three identified dates following the order.

Review of the progress notes recorded by RN #136 on the identified date and time showed that resident #036 was sleeping at the identified time, and resident #036 was found having a specified medical condition at another identified time later.

In an interview with RPN #138, they stated on the identified date that resident #036 was brought to the nursing station by PSW #147 and RA #134 in the afternoon. RPN #138 performed specified care in response to the resident's specified health condition, and the resident was taken back to bed. RPN #138 stated they reported resident #036's health condition to RN #137 after they completed the specified care, and it was the responsibility of RN #137 to assess the resident from that point.

RN #137 was not available to be interviewed by the inspector. Review of the home's records showed that RN #137 received report from RPN #138, however did not assess the resident or complete the specified care. Review of another home's record showed that on the identified date and times, RN #137 went to resident #036's room after receiving report from RPN #138 and returned to the nursing station.

Review of resident #036's progress notes recorded by RN #137 indicated on the above mentioned date, resident #036 returned to the floor with the specified health conditions, and the resident would be monitored. Review of the home's records showed that RN #137 could not recall if they completed the specified care for resident #036 on that shift. Further review of the home's records showed that RN #137 had failed to perform the specified care.

In an interview with RN #136, they stated they received report from RN #137 about resident #036's specified health condition, and PSW #145 reported that the resident was in bed during the identified time period. RN #136 stated at an identified time later, they found resident #036 with the specified medical condition. RN #136 stated they did not initiate the specified treatment for resident #036 or take an identified action, however immediately notified the resident #036's family. RN #136 stated that they were not aware

that resident #036 had consented for the specified approach to treatment. RN #136 stated that in the event a resident was found with the identified medical condition, they were expected to call the family and request if they wanted the specified treatment for the resident. RN #136 acknowledged that the incident was neglectful.

Review of the home's policies indicated that if a resident is found with the specified medical condition, the specified actions should be taken and the specified treatment will be performed to the resident and as part of the resident's plan of treatment.

In an interview with the DOC and ED, they stated for a resident with an identified care directive, the resident would be assessed and sent to hospital. The DOC stated if it was a witnessed specified medical condition, the specified approach to treatment would be performed and the specified action would have to be taken. The ED acknowledged that resident #036 was not monitored and provided with the care that resident #036 required. The DOC stated that for resident #036, the specified actions should have been taken. The DOC and ED acknowledged that resident #036 was neglected by staff. [s. 19. (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 residents are protected from abuse by anyone and not neglected by the licensee or staff, to be implemented voluntarily.

Issued on this 14th day of January, 2019

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

Original report signed by the inspector.