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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Oct 14, 2015	2015_293554_0013	O-002448-15	Complaint

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

WINBOURNE PARK
1020 Westney Road North AJAX ON L1T 4K6

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

KELLY BURNS (554)

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 5-7, 2015 (on-site)

Complaint Intake #O-002448-15

Complaint intake was related to the management of health status changes, specific to Resident #001.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI-Coordinator, Education Coordinator, and Family.

During the course of this inspection, the inspector reviewed: clinical health records for deceased resident, reviewed home policies, including Oxygen Therapy, Management of Concerns/Complaints, and Dementia Care.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 6 (11) (b), by not ensuring that the resident was reassessed and that the plan of care was revised because care set out in the plan had not been effective, nor had the licensee considered different approaches in the revision of the plan of care, for Resident #001, specific to change in health status.

Resident #001 has a diagnosis that includes cognition impairment, and respiratory disorders. Resident #001 requires the use of a continuous therapy.

Resident #001's health declined on a specific date; resident was found in bed, lethargic and not responding to verbal command. Resident was transferred to hospital and returned later that same date; resident was prescribed a change in medications. Registered Practical Nurse indicated in a progress note that resident remained disorientated, following return from hospital.

Interviews, with Registered Nursing Staff, Director of Care and resident's Attending Physician all indicated Resident #001 was diagnosed with a specific medical condition while at hospital, and was prescribed a specific treatment.

According to progress notes, the hospital contacted the LTC home on a specific date indicating the need to change Resident #001's medications, due to resident's confirmed diagnosis; new orders were received and initiated.

Progress notes, for Resident #001, were reviewed for the period of approximately ten days, the progress notes indicated resident's health declined over this same time period and Resident #001 required transfer back to the hospital for further assessment and treatment.

Resident #001 did not return to the long-term care home.

Resident #001's clinical health record was reviewed, including progress notes, and care plan, medication administration record, and physician's orders for the period indicated above; there was no documented evidence that the plan of care was reassessed or revised despite a change in Resident #001's health status and decline.

Director of Care indicated it would be expected that registered nursing staff would have reviewed and revised the plan of care noting resident's decline in health, and such would have included contacting the Attending Physician.

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 there is a process in place and monitored, ensuring that the resident was reassessed and that the plan of care was revised because care set out in the plan had not been effective, nor had the licensee considered different approaches in the revision of the plan of care, specifically when a resident's health status declines, to be implemented voluntarily.

WN #2: 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 failed to comply with O. Reg. 79/10, s. 53 (4) (b), by not ensuring that for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours, where possible.

Resident #001 required the use of a continuous therapy. Family Physician indicated resident was very regimented in his/her routines, especially when it came to wearing the ordered therapy.

Progress notes reviewed during the period of approximately ten days, indicated that Resident #001 exhibited a new responsive behaviour.

Registered Nursing Staff indicated that resident was found on four occasions without his/her prescribed therapy on and related equipment in his/her hand; registered nursing staff indicated Resident #001 was removing the prescribed therapy and indicated that such may have resulted from Resident #001's increased disorientation during the above review period.

Family of Resident #001 indicated during an interview, that he/she had brought this concern to the attention of registered nursing staff several times.

Resident #001's physician indicated no awareness of resident exhibiting this responsive behaviour.

A review of the clinical health record, including progress notes and care plan, indicated that Resident #001 "tends to remove prescribed therapy" but failed to provide documented evidence of any strategies developed or implemented to ensure resident was wearing the prescribed therapy to maintain therapeutic levels.

Director of Care indicated that Resident #001's plan of care should have been updated to include strategies to be implemented (and monitored) when it was known resident was removing a prescribed therapy.

2. The licensee failed to comply with O. Reg. 79/10, s. 53 (4) (c), by not ensuring that, for each resident demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments, interventions, and that the resident's responses to interventions are documented.

Family of Resident #001 indicated that Resident #001's physical and cognitive health declined rapidly over a short period of time; and that resident was sent to hospital twice during specific months. Family indicated that they arrived several times to visit Resident #001 and found him/her without the prescribed therapy in place and noted resident to be increasingly disoriented.

Interviews with registered nursing staff, personal support workers and Director of Care indicated Resident #001 exhibited several responsive behaviours; the clinical health record, including Resident #001's plan of care confirmed resident had a history of responsive behaviours.

Director of Care indicated a referral had been sent to a community outreach program, on a specific date, when resident was exhibiting "a new responsive behaviour", but due to changes (with the outreach program) Resident #001 was not seen by the outreach program.

Progress notes, reviewed for the period of approximately ten days, detailed Resident #001 demonstrating specific responsive behaviours.

Of the progress notes reviewed, during the approximate ten day review period, there were thirty progress notes detailing Resident #001's responsive behaviour, but no documented evidence of the action taken by staff, nor resident response or if resident settled; during this same time period, there were twelve incidents where the only action taken by registered nursing staff was to administer medication, of which, five of these incidents the medication was noted as ineffective, no further action was prompted by registered nursing staff, including contacting the resident's physician for further direction and or needed assessments.

During the period reviewed, there were six dates in which the family of Resident #001 voiced concern as to resident's cognitive change (or overall decline).

Director of Care indicated that it would be expected that registered nursing staff document the responsive behaviour that a resident is exhibiting, as well as the action taken and response of the resident.

Director of Care indicated that if a resident continued to exhibit a responsive behaviour despite planned interventions, it would be an expectation that registered nursing staff contact a physician for further direction.

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 there is a process in place and monitored, ensuring that for each resident demonstrating responsive behaviours, (b) strategies are developed and implemented to respond to these behaviours; and to ensure that for each resident demonstrating responsive behaviours, that actions are taken to respond to the needs of the resident, including assessments, reassessments, interventions, and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 131 (2), by not ensuring that drugs are administered in accordance with the directions for use specified by the prescriber.

Family of Resident #001, indicated arriving at the LTC home on a specific date and time, to find resident without his/her prescribed medical treatment/therapy on; family indicated Resident #001 was "blue" in colour. Family indicated reapplying resident's prescribed treatment/therapy and calling for help.

Progress note, (for a specific date) and written by Registered Nurse #018, indicated upon his/her arrival to Resident #001's room, resident was not found in any distress, and that resident's prescribed treatment/therapy was on and set at an specific flow rate (not prescribed flow).

Registered Nurse #018, indicated in an interview, that she recalls "Resident #001's family

member being extremely upset as to Resident #001's prescribed treatment/therapy not being applied"; RN further indicated family commented that the specific therapy hadn't been working. RN #018 reviewed his/her progress notes, and indicated that Resident #001's prescribed
treatment/therapy had been set at a specific flow rate, upon his/her arrival to resident's room and remained at the same flow rate when he/she exited the room following assessment of the resident.

Physician's order is for the prescribed treatment/therapy to be at set a prescribed flow rate (continuously); which was not the case at the time of the incident.

Registered Nurse #018 indicated not being aware of what the physician's order was to have been, for the prescribed treatment/therapy, indicating the Registered Practical Nurses are responsible for medication administration. RN #018 indicated prescribed treatment/therapy is considered a medication.

Registered Practical Nurse #019, assigned to Resident #001's home area, indicated not being aware that Resident #001's prescribed treatment/therapy had not been set to the prescribed flow as prescribed by Attending Physician.

Family of Resident #001 indicated, to the inspector, that this was not the first time he/she had arrived at the LTC home to find Resident #001 not wearing the prescribed treatment/therapy.

The home's policy, Oxygen Therapy (#LTC-F-120) directs that oxygen equipment will be checked at the beginning of every shift and periodically throughout the shift, ensuring accurate flow rate and patency of the tubing and mask.
Director of Care indicated it would be an expectation, that oxygen settings would be assessed, by registered nursing staff, at the beginning of a shift and throughout one's shift. Director of Care indicated the oxygen would be considered a medication and that physician's orders are to be followed.

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 there is a process in place and monitored, ensuring drugs are administered in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 10th day of November, 2015

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

Original report signed by the inspector.