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

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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
Nov 23, 2017	2017_538144_0045	024457-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

Long-Term Care Home/Foyer de soins de longue durée

RIVERSIDE PLACE
3181 Meadowbrook Lane WINDSOR ON N8T 0A4

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

CAROLEE MILLINER (144), ANDREA DIMENNA (669)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 30, 31, November 1, 2, 3, 2017.

The following intakes were completed within the RQI:
- 034141-16, IL-483667-LO - Complaint related to pain management and the plan of care
- 000987-17, IL-48830-LO - Complaint related to alleged abuse and missing personal items.

During the course of the inspection, the inspector(s) spoke with more than 20 residents, three family members, President of the Residents' Council, the Executive Director, Interim Director of Care, Assistant Director of Care, the Registered Dietician, Recreation Manager, one Registered Nurse, five Registered Practical Nurses, fifteen Personal Support Workers, one Physiotherapy Assistant and four Dietary Aides.

During the course of the inspection, the inspector(s) toured the home, observed medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, policies and procedures, posting of required information and observed resident to staff interactions, the provision of resident care and general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and compliment each other.

A) During stage one of the RQI, one resident was observed on one occasion with a restraint in use.

During stage two of the RQI, the same resident was observed on a second occasion with a restraint in use.

The Inspector noted that the resident's assistive device included a tag that outlined directions for use of the restraint.

The home's policy, Personal Assistance Service Device (PASD)-Index: CARE10-O10.03, modified October 16, 2016, was reviewed and stated that a PASD may be included and used as part of a resident's plan of care when the following was met:
- the PASD had been approved by the Physician, Registered Nurse, Registered Practical Nurse, Occupational Therapist, or Physiotherapist
- informed consent for PASD (non-bed rail) had been obtained from the resident or Substitute Decision Maker (SDM) (for the incapable resident)
- would be documented in the resident's progress notes; the resident's plan of care had

individualized resident goals and interventions.

The resident's clinical record was reviewed and did not include information, assessment, or instruction for the use of a restraint.

One PSW said that there was no direction in the resident's chart about use of a restraint. A second PSW said that the restraint observed by the Inspector was only used when the resident was napping and when directed by the nurse.

One RN acknowledged that the resident's information in Point Click Care (POC) was not current and that there was no inclusion in the care plan about the resident using a restraint.

The Physiotherapy Assistant (PTA) said there was a label on the residents' assistive device that indicated how the restraint was to be used and that they believed the restraint use was documented somewhere on a PASD hard copy sheet in the resident's chart. The PTA acknowledged that the resident could not get out of their assistive device even if the restraint was not used.

B) During stage one of the RQI, a second resident was observed on one occasion with a restraint in use.

During stage two of the RQI, the second resident was observed on two occasions with a restraint in use.

The Inspector noted that the resident's assistive device included a tag that outlined directions for use of the restraint.

The resident's clinical record was reviewed and did not include information, assessment, or instruction for the use of a restraint.

The POA for the resident stated that the resident was unable to get out of their assistive device even when the restraint was not used and that the restraint did not inhibit the residents' movement. The POA recalled that the restraint had been used for the resident for the past three to four months. The POA reported that the home had never discussed the restraint with them, other than the PTA who had once said that the restraint would help the resident relax.

One PSW said that there was no information and direction in Point of Care (POC) about a restraint for this resident and that they had never seen a restraint used for this resident.

A second PSW said that POC would not include instructions on when to use the restraint and that the restraint would only be used with the resident when they were napping and when directed by the nurse. The PSW shared that staff did not use a restraint for this resident. The PSW checked the resident's POC and noted there was no direction for use of a restraint with this resident.

One RN reviewed the resident's POC, PCC tasks, and care plan and stated that there was no inclusion of the resident using a restraint and that even if the restraint was used for comfort, it should be included in the physician’s orders and include POA consent.

The Physiotherapy Assistant (PTA) explained there was a label on the resident's assistive device that indicated how the restraint could be used and that they believed use of the restraint was documented somewhere on a PASD hard copy sheet in the resident’s chart.The PTA acknowledged that the resident could not get out of their assistive device even if the restraint was not used. The PTA explained that there should be a progress note from the Occupational Therapist (OT) in PCC about use of the restraint.The PTA searched the resident's PCC and did not find a progress note related to the restraint that was in use.

The Interim Director of Care (IDOC) stated that residents were assessed by registered staff for use of a restraint after discussion with the family, staff, and physiotherapy. The IDOC explained that if the resident was unable to reposition themselves and the observed restraint had no restraining qualities, there would still be a progress note documenting consent for the restraint to be used and it would be documented in the resident’s care plan.The IDOC added that physiotherapy staff placed tags on the assistive devices with directions to indicate how the restraint could be used which should also be included in the care plan.

The IDOC said that the length of time the restraint was used by a resident was based on the judgment of nursing staff and that it usually was not used more than two hours. The IDOC stated that PSWs should check a resident’s care plan or ask registered staff before applying a restraint. The IDOC checked the care plans for both of the above identified resident's and acknowledged that there was no inclusion about use of a restraint in either of the care plans. The IDOC said that the use of a restraint should be included in the written care plan and further acknowledged that a restraint should not be used if it was not included in the resident's care plans.

The Executive Director acknowledged that the care provided to the above two residents related to use of a restraint was not consistent among staff.

The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the above identified residents written plans of care so that they were consistent. [s. 6. (4) (b)]

2. 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.

During stage one of the RQI, a resident was identified as having had a decline in one of their activities of daily living (ADL) from their date of admission to the home's 90 day post-admission Minimum Data Set (MDS) assessment.

The resident's Point of Care (POC) Tasks were reviewed and included interventions to address the resident's decline.

The physician’s orders and resident's care plan were reviewed and were consistent with the POC tasks.

The Resident Roster binder from one resident home area was reviewed and did not include the same instructions as the POC tasks, physician's order's and the resident's care plan related to the resident's identified decline.

The resident's progress notes were reviewed. Two progress notes documented two weeks apart, were consistent with the POC tasks, physician's order's and the resident's care plan related to the resident's identified decline.

During observation of the resident during the lunch and supper meals on one identified date, it was noted that the resident was not provided with their dietary interventions as specified in their POC tasks, physician's order's and care plan. One RPN was observed providing the resident with one intervention by use of a spoon. One Dietary Aide (DA) agreed that the resident was not provided with the interventions included with their POC tasks, physician's orders and care plan.

During observation of the breakfast meal on another identified date, it was noted that the resident was not provided with their dietary interventions as specified in their POC tasks,

physician's order's and care plan. One DA agreed that the resident received the incorrect dietary intervention.

During observation of the resident during the lunch meal on a third identified date, it was noted that the resident was not provided with their dietary interventions as specified in their POC tasks, physician's order's and care plan. The Registered Dietician (RD) acknowledged that the resident was not provided with the correct dietary intervention.

One PSW stated that resident diets were documented on POC and preferences were in the roster binder. The PSW correctly reported the current diet for the resident.
Two DA's said that resident diet and food preferences were documented in the roster binder.

A third DA that was covering for the Nutrition Manager explained that each Monday a report was printed of the RD’s progress notes from the previous Friday, and they (the DA) then updated the roster binders. The DA reviewed the RD’s progress notes identified by the Inspector and acknowledged that the roster had not been updated.

One RPN identified one of the resident dietary interventions and explained that the intervention was prepared by registered staff at the medication cart.

A second RPN also identified the resident's dietary interventions and acknowledged one of the interventions was provided on a spoon.The RPN stated that this particular intervention started a couple weeks before the RQI and that the intervention was always provided to the resident on a spoon.

One RN reviewed the resident's physician’s orders and stated that despite the order for one particular dietary intervention, perhaps RPN's provided a different dietary intervention to the resident if they were concerned about the residents' swallowing and that the order should have included a progress note or referral to the dietitian. The RN reviewed the clinical record for the resident and did not find an RD referral related to swallowing.

The IDOC reviewed the resident's physician’s orders and acknowledged that the physician's dietary intervention orders should have been followed.

The RD shared that when they made changes to a resident’s diet, the RD would make the changes in the roster binder, write a physician’s order, and speak verbally to the RPN

and DA on the unit. The RD explained that staff would use the roster binder or the sheet on the beverage cart to refer to what interventions were required for the resident. The RD reported that one identified intervention was normally provided from a glass unless the RD specified that a spoon should be used.

The RD reviewed the resident's physician's orders, POC tasks, and roster, and stated that they expected the resident to receive the dietary interventions that were ordered.

The licensee has failed to ensure that nutrition orders set out in the plan of care were provided to resident #004 as specified in the plan.

The severity of this non-compliance was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection.There was a compliance history of this legislation being issued in the home on October 3, 2016, as a Voluntary Plan of Correction (VPC) with the Resident Quality Inspection (RQI) inspection number 2016_419658_0009. [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 staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a registered dietitian who was a member of the staff of the home completed a nutritional assessment for all residents on admission and whenever there was a significant change in a resident’s health condition.

During stage one of the RQI, a resident was identified as having had a decline in one of their activities of daily living.

The home's policy, Nutritional Care and Hydration (Index Care7-010.01), reviewed July 31, 2016, was reviewed and stated that within 14 days of move-in, the RD completed an Initial Nutrition Assessment in PCC.

The resident's Assessments in PCC were reviewed. A Nutrition Admission Assessment was not noted. The resident’s progress notes were reviewed. The RD’s first assessment note was dated one month after the resident was admitted to the home.

The RD explained that nutrition assessments were completed for new admissions within 14 days and that the assessments were documented in the PCC Assessment section of the electronic clinical record. The RD said that the clinical record would also include a progress note about the assessment. The RD reviewed the resident's assessments in PCC and progress notes and acknowledged that an admission nutrition assessment was not completed for the resident and should have been.

The licensee has failed to ensure that a registered dietitian completed a nutritional assessment for resident #004 on admission.

The severity of this non-compliance was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 26. (4) (a),s. 26. (4) (b)]

Issued on this 4th day of December, 2017

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

Original report signed by the inspector.