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
Mar 20, 2019	2019_618211_0004	026078-18, 027675-18	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

Montfort
705 Montreal Road OTTAWA ON K1K 0M9

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

JOELLE TAILLEFER (211)

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 12, 14, 15, 19, 20, 21, 22, 2019 and March 6, 7, 2019.

The following intakes were completed in this complaint inspection:
Log #026078-18 related to Prevention of Abuse, Medication, Skin and Wound Care and Nutrition Care,
Log #027675-18 related to Responsive Behaviours, Minimizing of Restraining and Residents' Council.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Food Services Manager, Associate Director of Care (ADC), Registered Nurses (RN), Registered Practical Nurses (RPN), several Personal Support workers (PSW), Dietary Services Staff, a resident and a resident's family

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Medication
Minimizing of Restraining
Nutrition and Hydration
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following are documented:
   1. The provision of the care set out in the plan of care.
   2. The outcomes of the care set out in the plan of care
   3. The effectiveness of the plan of care.

Resident #001's SDM contacted the Ministry of Health and Long-Term Care on an identified date stating that resident #001's responsive behaviours had worsened since the beginning of an identified month.

Inspector #211 and PSW #119 approached resident #001 sitting in a specific wheelchair on an identified date and observed resident #001's responsive behaviours. The resident was informed that one of the device on the specific wheelchair will be removed. While removing the device, the resident looked at PSW #119 with angry eyes and showed that the intention was to demonstrate a responsive behaviour toward PSW #119.

Resident #001's plan of care within one year, indicated that the resident had multiple responsive behaviours toward the staff and was resistive during care.

Review of the resident's health care records indicated that the resident was being followed by the Geriatric Psychiatry Outreach Team and the Behavioral Support Ontario (BSO) in an identified year.

Review of the physician's order on an identified date, indicated to increase an identified medication to a specific dosage once a day.

The Geriatric Psychiatry Outreach Team (GPOT) follow-up on an identified month indicating that the increase of the identified medication had not showed result to the resident's responsive behaviours. The suggestion was to increase an identified medication for two different specific doses twice a day. One month later, the GPOT indicated that three identified medications were eliminated and one medication to be decreased.

Inspector #211 reviewed the forms titled "Feuille de surveillance des comportements" (Behaviour Monitoring Form) and observed that the documentation on the sheets was not complete for eighty-two days at different specific times within four months.

In an interview with the DOC on an identified date, confirmed that the forms titled "Feuille de surveillance des comportements" was not documented hourly.

The licensee has failed to ensure that the hourly monitoring for the resident's responsive behaviours were documented within four months to determine the following:
1. The provision of the care set out in the plan of care
2. The outcomes of the care set out in the plan of care
3. The effectiveness of the plan of care. [s. 6. (9)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care are documented.

Review of the resident #001's progress notes for an identified date, indicated that the resident's mobility had declined. The resident was able to walk a certain amount of steps with a specific device and the assistance of one person. A borrowed wheelchair was given to the resident as a trial.

Review of the physician's order on an identified date, indicated to use a specific restraint to the resident's wheelchair to prevent falls.

According to the legislation under O. Reg 110 (2), the licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for the purpose
4. That the resident is released from the physical device and repositioned at least every two hours.

Review of the forms titled "Formulaire d'observation de contention" (Restraint Monitoring Form) revealed that fifteen identified days at specific times within two months were not documented.

In an interview with the DOC on an identified date indicated that resident #001 was able to remove the identified restraint during that time and the licensee should have asked the physician to change the order for a personal assistance services device (PASD). The DOC stated since the physician's order was prescribed as a restraint, the staff should had recorded as indicated on the specified forms titled "Formulaire d'observation des contentions", as followed:
1. Every hours to verify the resident's safety, comfort and positioning, and

2. Every two hours that the identified restraint device was released and repositioned.

The licensee has failed to ensure that the provision of the care set out in the resident #001's plan of care related to the restraint's requirement as indicated above was documented. [s. 6. (9) 1.]

3. Resident #001 was observed by inspector #211 on two different days, sitting in a specific wheelchair in the resident's unit. During these observations, the resident's specific wheelchair was inclined at a determined angle with two identified devices placed in front of the resident's wheelchair.

Review of the physician order on an identified date, indicated that the specific wheelchair was for resident's comfort and to prevent further altered skin integrity. Furthermore, the physician's order indicated that two of the identified specific devices and the specific wheelchair were for positioning and comfort.

Review of the home policy #CARE10-010.03 titled LTC-Personal Assistance Service Device (PASD) in 2018, indicated that any resident that cannot independently reposition themselves or has an affected limb, must be repositioned at least every hour.

Resident #001 was diagnosed with cognitive impairment and other health conditions. Furthermore, the resident exhibited altered skin integrity.

In an interview with PSW # 118 on an identified date stated that resident #001 was verified and repositioned every two hours.

In an interview with the DOC on an identified date stated that the specific device was used to prevent resident #001 from sitting in the identified wheelchair in an awkward position. The application of the device was requested by the resident's substitute decision maker (SDM). The other specific device placed in front of the resident identified wheelchair was used for resident's specific activities. The identified wheelchair was used to prevent further issues with altered skin integrity.

In an interview with the DOC on an identified date indicated that when a resident used a PASD, the staff should documented that the resident was repositioned every two hours. The DOC stated since the changed of their Electronic Healthcare Records from the Mede-Care system to the PointclickCare (PCC) technology on an identified date on a specific month, the staff were documenting on both systems. The staff were documenting

on the forms titled "Formulaire d'observation des contentions" (Restraint Monitoring Form) and in the PCC under the Safety/Support Devices.

The DOC stated on an identified date that the staff were not recording the resident's repositioning in the identified wheelchair every 2 hours. Inspector #211 revised both following documents: for a specific month:
1. The forms titled "Formulaire d'observation des contentions" under the mede-care system,
2. In the PCC under the task titled "Contention Observation Form and the safety/support Devices".

The DOC confirmed that the resident's PASD related to the specific wheelchair and the two identified devices were not recorded every 2 hours for the resident's positioning for the identified hours during 16 days within a specific month.

The licensee has failed to ensure that the resident's provision of care set out in the plan of care related to the positioning was documented. [s. 6. (9) 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 the following are documented:
1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care
3. The effectiveness of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Review of resident #001's health care records indicated that the resident had a fall on an identified date.

RPN #105 documented in the resident's health care records on the identified date, that the resident was found sitting at the front of the bed. On that day, RPN #105 completed the form titled "Screening Fall Risk".

In an interview with DOC on an identified date, stated that RPN #105 didn't use the clinically post-fall assessment instrument for resident #001's fall on the identified date.

The licensee has failed to complete a clinically appropriate post-fall assessment instrument for resident #001's fall on the identified date. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: 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 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.

Resident #001's family member reported through a telephone call on an identified date, that resident #001 had two deep long identified altered skin integrity on a specific body area. The family member indicated receiving different information related to the cause of resident's altered skin integry by two different staff.

Review of resident #001's progress notes for an identified date indicated that the resident had an altered skin integrity on a specific body area.

On an identified date and time, indicated that the substitute decision maker (SDM) visited the resident just after the resident's fall. The resident #001's SDM asked RN #105 the cause of the two altered skin integrity on the resident's body area. The notes indicated

that a specific area of the altered skin integrity on an identified body area was old and the posterior specific altered skin integrity was new.

One day later, RPN #106 documented that three close altered skin integrity areas on a specific part of the resident's body were found by the SDM. RPN #106 indicated that the altered skin integrity area could have occurred during the resident's fall.

Three days later, RPN #101 documented that the resident's SDM was informed eight days prior today that an old altered skin integrity area was found on the resident specific body area. Nine days later, RPN #101 wrote that the resident's altered skin integrity to the identified body area continue to be healing.

Review of the home's policy titled LTC-Bruises, Rashes, incontinence-associated dermatitis (IAD) and Abrasions #12-010.04 indicated the following:
-Classify alteration of skin integrity: Bruise, rashes, IAD and abrasions
-Document in the progress notes; location, size, color, characteristics, screen for pain
-Record on Monthly Skin Integrity report.

In an interview with the DOC on an identified date, indicated that the licensee doesn't use a clinically appropriate assessment instrument that is specifically designed for skin and wound when a resident's skin has that specific altered skin integrity. This type of altered skin integrity will be documented in the progress notes only. However, the DOC stated that the measurement, the color and length of the specific altered skin integrity should have been described.

The licensee has failed to ensure that a resident exhibiting altered skin integrity used a clinically appropriate assessment instrument that is specifically designed for skin and wound for resident #001's identified type of altered skin integrity to the specific body area. [s. 50. (2) (b) (i)]

2. Review of resident #001's progress notes within 11 months, indicated that the licensee did not used a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment for resident that was exhibiting altered skin integrity for the following dates:
1. RPN #101 documented on an identified date, that a altered skin integrity was found to an identified body area with specific numbers without the unit of measurement. Another region of the same identified body area indicated numbers without the unit of measurement. On the same day, the physician documented that a different region of the

same identified body part sustained an injury.
2. RPN #102 documented 13 days later that the specific area of the identified body part had a specific color without opening of the area. Treatment and a specific intervention were apply to protect the skin.
3. Thirty day later, the resident's progress notes indicated that an evaluation revealed an area on the identified body part with a specific measurement. The area was intact.
4. Four days later, the notes indicated that the specific area of the body had a small opening and identified treatment was applied. Four days later, the notes indicated that the identified altered skin integrity on the specific body area was intact.
5. Sixteen days later, the progress notes documented by RPN #101, indicated that the resident has a new altered skin integrity on another body part area with specific measurement. The surrounding edge of the altered skin integrity was red and there was transparent liquid inside the wound. However, the physician notes documented the next day, that there was swelling present on the two different body parts without altered skin integrity.

A head to toe skin assessment form was completed in the point click care (PCC), 11 days later after resident's identified leave of absence. The form indicated that resident #001 had altered skin integrity to both identified body parts suspecting deep tissue injury. The two identified body parts had a specific altered skin integrity with specific measurements.
6. Three days later, resident #001's progress notes written by RPN #102 indicated that both body parts areas were identified as acute altered skin integrity injuries.
7. Twenty-nine days later, the progress notes indicated that a dry skin from an identified body area started to be dislodged. Two days later, the same body part had an open area.
8. The next day, resident #001's progress notes described that the same identified body area's dressing was soiled with blood and the altered skin integrity had a identified measurement with a superficial depth with the presence of a identified color scabs. Three days later, the physician's progress notes documented that there was an altered skin integrity on both identified body parts and one of them was worst. Two days later, the notes indicated that there was yellow secretion from the altered skin integrity of one of the identified body area.
9. Thirty-one days later, the progress notes indicated that the identified body area had an altered skin integrity with a specific color crust and an identified measurement without liquid present. The other identified body part's skin was intact with a specific condition.

In an interview with the DOC on an identified date stated they found two forms titled "Formulaire d'evaluation continue des plaies" designed specifically for wound

assessment for both identified body areas on two different dates.

The licensee has failed to ensure to use a clinically appropriate assessment instrument that is specifically designed for skin and wound when resident #001 developed altered skin integrity for both body areas related to two specific dates. [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
(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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was well maintained.

Review of resident #001's progress notes indicated that the resident's specific device on the resident's wheelchair was broken on an identified date and was still not repaired nine days later.

Review of the physician's order on an identified date, indicated that the identified device to the resident's wheelchair was to prevent falls. The physician's order related to the resident's identified restraint was changed to a PASD approximately four months later.

In an interview with the DOC on an identified date stated that the physiotherapist informed the occupational therapist through an email on an identified date, that resident #001's specific device restraint needed to be repaired and the resident specific device was repaired on the same day. The DOC revealed that the resident's identified device was not repaired after nine days later because the physiotherapist was not notified by the staff when the resident's device was broken. The DOC believed that the resident's device restraint was broken because it had been caught in an identified equipment. The DOC indicated the resident was able during that time to remove the device, but since the physician's order was still indicating that the device was a restraint to prevent resident's falls, the device should have been repaired immediately when it was found broken.

The licensee has failed to ensure that the resident's identified device restraint to prevent falls was well maintained for nine days. [s. 110. (1) 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 o ensure that the physical device was well maintained, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home who received a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

On an identified date, the executive Director received an email from resident #001's substitute decision maker (SDM) that indicated that Dietary Aide #115 did not follow the preparation of a identified food pre-established by the DOC and the Food Service Manager.

Resident #001 substitute decision maker (SDM) wrote on the email that the food brought by PSW #116 was served boiling to the resident without two other elements. The resident's SDM indicated that if the family member was not present when the food was served, the resident's mouth would have be burned. In addition, the resident was unable to spread an identified nutrient substance on the bread.

In an interview with the DOC on and identified date, they indicated that the written complaint from resident #001's SDM was not forward to the Director when the SDM's concern was emailed on the identified date.

The licensee failed to forward the written email complaint to the Director on the identified date. [s. 22. (1)]

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.