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
Jan 23, 2020	2020_618211_0002	022159-19	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): January 8, 9, 14, 15, 2020.

A complaint inspection, log #022159-19, was conducted related to alleged neglect of resident care as well as concerns related to the provision of personal care and dressing.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Recreation Manager, Education Manager, the Clinician, a Registered Nurses (RN), a Registered Practical Nurses (RPN), the Behavioural Support Ontario Personal Support Worker (BSO/PSW), several Personal Support Workers (PSWs), a Recreation Therapist, an activity aide, several residents and a family member.

During the course of the inspection, the inspector reviewed resident health care records, Medication Administration Records, Resident's Bath Schedule Sheets, Outpatient consultation Reports, Multidisciplinary Conference Form, identified Observation System form, Multi-Month Participation Report and an identified policy.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

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 there is a written plan of care for each resident that sets out,
(c) clear direction to staff and others who provide direct care to the resident.

In an interview with RN #116 on an identified date, stated that resident #004’s medications were administered and hidden within a specific beverage since the resident’s admission, because the resident was refusing to take them. RN #116 disclosed that recently, they had to hide the medication inside another identified item to be able to administer them at a specific time.

Review of resident #004’s medication administration record (MAR) and the plan of care doesn’t indicate how to administer the resident medication.
In an interview with the DOC on an identified date, stated to ensure conformity in resident ’s medication administration at the specific shift and time, it should be written in the resident’s MAR and their plan of care.

The licensee has failed to ensure that the written plan of care for resident #004 sets out, clear direction how to administer the resident’s medication. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan is provided to the resident as specified in the plan.

Review of resident #004's plan of care on an identified date, indicated that the resident refused assistance or supervision for hygiene care or bath.

Review of the Point of Care (POC) in the electronic Point Click Care System under the section bathing since the last two months, indicated that the resident was bathed on two specific dates and received a sponge bath with staff assistance on an identified date, using the Gentle Persuasive Approach (GPA).

Review of a specific consult progress report on a specific date, indicated that the staff could use a promise such as two identified beverages to motivate the resident to take a bath.

In an interview with PSW #114 on an identified date, stated that the interventions suggested to motivate resident #004 to take a bath were:
-to use the Gentle Persuasive Approach techniques (GPA),
-the stop and Go approach, or
-by telling the resident that a special outing will be offered if the bath was taken.
PSW #114 stated that none of the above interventions were successful to motivate the resident to take a bath.

In an interview with the DOC on an identified date, stated not being aware of the identified consult suggestions to motivate resident #004 to take a bath. The DOC stated that one of the suggestions will be offered to the resident prior to the scheduled bath for the following shift.

The licensee has failed to ensure that the consult's suggestions were followed and provided to the resident as specified in the plan to evaluate if the suggested intervention could motivate the resident to take a bath. [s. 6. (7)]

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

Review of resident #004's consult progress report from a specific Health Care Group on

an identified date, suggested to offer resident two identified activities.

In an interview with the Recreation Aide #119 on an identified date, presented a copy of the Multi-Month Participation Report within three months for resident #004. The Recreation Aide stated that the activities that resident #004’s refused were not documented except one. The Recreation Aide revealed hearing that one of the suggested activities was tried, and the resident refused, but unfortunately it was not documented.

The licensee has failed to ensure that the provision, the outcomes and the effectiveness of the care plan related to the program activities were documented. [s. 6. (9)]

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 there is a written plan of care for each resident that sets out, clear direction to staff and others who provide direct care to the resident,
-to ensure that the care set out in the plan is provided to the resident as specified in the plan, and
-to ensure that the following are documented:
A. The provision of the care set out in the plan of care.
B. The outcomes of the care set out in the plan of care.
C. 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimal, interdisciplinary assessment of the following with respect to the resident:
15. Skin Condition, including altered skin integrity and foot conditions.

Review of resident #004's plan of care on an identified date, indicated that the resident is a risk of altered skin integrity because the resident refuses and resists care including skin assessment.

In an interview with the DOC on an identified date, stated that resident #004's fingernails and toenails care were not included in the resident's plan of care in the section hygiene and grooming. The resident's nails should be assessed and cut as needed during scheduled bath time.

The licensee has failed to ensure that the foot conditions, including nail care were included in the resident's plan of care. [s. 26. (3) 15.]

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 plan of care must be based on, at a minimal, interdisciplinary assessment of the following with respect to the resident: 15. Skin Condition, including altered skin integrity and foot conditions, 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).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to resident in accordance with the directions for use specified by the prescriber.

Review of resident #004’s medication administration record (MAR) for a specific month, indicated to administer an identified medication tablet sublingual at a certain dose as needed to reduce anxiety before a specific appointment.

Review of resident #004’s progress notes written by RN #116 on an identified date, indicated that the specific medication was crushed and put within an identified beverage to be administered to the resident on a specific time prior the appointment. However, the identified beverage with the crushed medication was refused by the resident.

The licensee has failed to ensure that the drug prescribed was prepared by RN #116 in accordance with the directions for use specified by the prescriber. Furthermore, the licensee could have failed to ensure that the medication was administered to resident #004 in accordance with the directions for use specified by the prescriber, if the crushed medication within the identified beverage would have been ingested by the resident. [s. 131. (2)]

2. The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Review of resident #004’s progress notes written by RN #116 on an identified date, indicated that the medication was put in a specific beverage. However, resident #004

refused to take the beverage from the nurse stating that a medication was inside the specific beverage. The identified beverage was given to a PSW. The resident accepted to drink the identified beverage from the PSW.

Review of resident #004’s medication administration record (MAR) for an identified month, indicated to administer the specific medication tablet sublingual at a certain dose as needed to reduce anxiety before a specific appointment.

Resident #004’s progress notes written by RN #116 on an identified date, indicated that the specific medication was crushed and put inside an identified beverage to be administered at a certain time prior an appointment. The identified beverage was refused by the resident. The family member was informed that the resident refused taking the medication that was put inside the identified beverage. The family member took the beverage with the crushed medication within the drink and went for the appointment with the resident. Later after the appointment, the family member informed the nurse that the identified drink with the crushed medication was not given since the resident refused drinking the identified beverage.

The licensee has failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse when the medication was given on the following dates:
-by a PSW on an identified date, and
-when RN #116 gave the crushed medication within the identified drink to the family member. [s. 131. (3)]

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 drugs are administered to resident in accordance with the directions for use specified by the prescriber, and
-to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

Issued on this 24th day of January, 2020

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

Original report signed by the inspector.