Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1

Original Public Report

Report Issue Date: December 21, 2023

Inspection Number: 2023-1083-0003

Inspection Type:
Complaint
Critical Incident

Licensee: Revera Long Term Care Inc.

Long Term Care Home and City: Thorntonview, Oshawa

Lead Inspector	**Inspector Digital Signature**
Susan Semeredy (501)	Susan L Semeredy Digitally signed by Susan L Semeredy Date: 2024.01.04 13:07:43 -05'00'

Additional Inspector(s)
Adelfa Robles (723)
Irish Abecia (000710)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5-8, 11-14, 2023

The following intakes were completed in this complaint inspection:

- Intake #00095491 was related to falls prevention and management and the prevention of neglect.

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00002110/CI: 2534-000015-21, Intake #00006106/CI: 2534-000006-22, Intake #00094147/CI: 2534-000039-23 and Intake #00104252/CI: 2534-000065-23 were related to the prevention of abuse.

- Intake #00086077/CI: 2534-000026-23 was related to the prevention of neglect.
- Intake #00006036/CI: 2534-000003-22 was related to personal care and services.
- Intake #00085577/CI: 2534-000021-23 was related to responsive behaviours.
- Intake #00090289/CI: 2534-000031-23 was related to medication management.
- Intake #00090809/CI: 2534-000034-23 was related to responsive behaviours and the prevention of abuse.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 6 (10) (b)
Plan of care
When reassessment, revision is required
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of

care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary;

The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the care set out in the plan was no longer necessary.

Rationale and Summary
A resident had a history of making inappropriate comments and gestures towards staff and was later observed being inappropriate with two residents. Several months later the resident was being inappropriate with another resident.

An intervention was implemented after the first incident with co-residents. This intervention was subsequently decreased and then discontinued before the second incident occurred. There was no reassessment or revision of the resident's plan of care between these two incidents.

A Registered Nurse (RN) indicated the resident did not have the intervention in place when the second incident occurred. The Director of Care (DOC) acknowledged there did not appear to be a reassessment of the resident nor a revision of their plan of care between the first and second incidents.

Failing to reassess the resident's behaviours before revising their interventions placed other residents at risk.

Sources: A resident's progress notes and interviews with an RN and the DOC. [501]

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)
Duty to protect
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).

The licensee has failed to ensure residents #005, #006, and #007 were protected from abuse by resident #004.

Rationale and Summary
Section 2 of the Ontario Regulation 79/10 defines sexual abuse as "any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member."

(i) Resident #004 was seen being inappropriate with resident #005.
(ii) On the same day, resident #004 was seen being inappropriate with resident #006
(iii) Several months later, resident #004 was seen being inappropriate with resident #007.

The DOC confirmed that resident #004 was abusive towards resident #005, #006, and #007.

Failing to protect residents from abuse placed them at risk for emotional and physical distress.

Sources: Residents' progress notes, critical incident reports and interviews with the DOC and other staff. [501]

WRITTEN NOTIFICATION: Plan of Care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
Duty of licensee to comply with plan
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.

The licensee has failed to ensure that the care set out in the plan of care for a resident related to a fall prevention device was provided as specified in the plan.

Rationale and Summary
Video footage from a resident's surveillance camera, revealed a Personal Support Worker disabling a resident's fall prevention device.

The resident's plan of care indicated this device was to be in place when the resident was in bed.

Two staff members stated that the resident was at risk for falls and the resident started having this device after a fall. The Executive Director (ED) agreed that based on the video footage, the PSW rendered the device inoperable.

There was an increased risk to the resident when their falls prevention device was not provided as specified in the plan.

Sources: A resident's plan of care, video footage taken and interviews with the ED and other staff. [723]

WRITTEN NOTIFICATION: Plan of Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.
Plan of care
Documentation
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.

The licensee has failed to ensure that the provision of the care set out in residents #008 and #009's plan of care was documented.

Rationale and Summary
(i) Resident #008's documentation survey report in Point Click Care (PCC) for a month, indicated there were several areas on several days and shifts that care being provided was not documented.

(ii) Resident #009's documentation survey report in PCC for twelve days indicated there were several areas on several days and shifts that care being provided was not documented.

The DOC acknowledged this was an area that needed improvement.

Inconsistently documenting residents' provision of care put them at risk for inaccurate reassessments.

Sources: Resident #008 and #009's documentation survey report and an interview with the DOC. [501]

WRITTEN NOTIFICATION: Duty to Protect

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (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.

The licensee has failed to ensure that a resident was protected from abuse from staff.

Rationale and Summary

Section 2 (1) of the Ontario Regulation 246/22 defines emotional abuse as "any threatening, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident."

Video footage taken from the resident's surveillance camera inside the resident's room, showed a PSW entered the room without addressing the resident and made remarks indicating the resident's fall prevention device was annoying.

The ED acknowledged this PSW's action and response to the resident was not a person-centered approach, violated their policy on Code of Conduct and was considered abuse as the PSW shunned and failed to acknowledge the resident.

There was a risk of distress to the resident when they were not protected from abuse.

Sources: Video footage and an interview with the ED. [723]

WRITTEN NOTIFICATION: Bathing

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee has failed to ensure that a resident was bathed by the method of their choice.

Rationale and Summary
A resident's plan of care indicated the resident's preference was to receive a tub bath. Review of the resident's bathing records indicated they received more showers than baths.

Staff members indicated they were aware the resident preferred baths, but the bathtub in their home area was not working properly for several months. The ED confirmed the bathtub was broken and took time to repair.

Because the bathtub was not fully functional, the resident did not receive their bathing preference.

Sources: A resident's bathing records, plan of care, home's Service Call Reports, and Thortonview Maintenance Request Task. [723]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, 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,

The licensee failed to ensure that a resident received 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, when they sustained a skin tear.

Rationale and Summary
A resident exhibited responsive behaviours that resulted in altered skin integrity. An RPN treated the wound at the time of the incident and reported it to the assigned nurse.

The home's procedures for new skin impairment or wound indicated that the nurse completes the initial assessment once it has been reported or identified. However, a review of the resident's clinical records indicated that an assessment had not been completed for their altered skin integrity. The DOC confirmed that there was no

assessment completed.

Failure to assess the resident's altered skin integrity could lead to the home's inability to monitor the wound's progress and manage accordingly.

Sources: A resident's clinical records; Procedure titled "LTC - New Skin Impairment/New Wound Assessment", modified date: May 10, 2023; Interviews with the DOC and other staff. [000710]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (1) 1.
Responsive behaviours
s. 58 (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

The licensee has failed to comply with the system to ensure that written approaches to care including screening protocols, assessment and reassessment that may result in responsive behaviours of a resident was complied with.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure that a policy is developed to meet the needs of residents with responsive behaviours and must be complied with.

Specifically, the home failed to comply with the policy, "Suicide Prevention" reviewed on March 31, 2023, when assessments and reassessments of a resident were not completed and re-evaluated when they attempted self-harm.

A resident was admitted to the home with a history of self-harm and an assessment was completed upon admission. Progress notes for approximately six months indicated several expressions and attempts of self-harm while the resident was in the home.

The home's policy indicated that all residents deemed at risk would have a comprehensive assessment completed and re-evaluated on as needed basis using a took found in Point Click Care (PCC).

Staff indicated that this tool was expected to be completed when a resident expressed self-harm as per the home's policy. The ADOC and ED both stated that staff were expected to comply with the home's policy.

There was an increased risk of harm when the home failed to complete an assessment for a resident according to their policy.

Sources: A resident's assessment records, home's Policy: LTC Suicide Prevention, Index: CARE19-P10 reviewed on March 31, 2023, interviews with an RPN, RN and other staff. [723]

WRITTEN NOTIFICATION: Sending of Drugs with a Resident

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 137
Sending of drugs with a resident
s. 137. Every licensee of a long-term care home shall ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with them when they leave the home on a temporary basis or are discharged.

The licensee has failed to comply with the system to govern the sending of medications prescribed to a resident when they left the home on a temporary basis.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee is required to ensure that a policy is developed and approved when sending medications prescribed to a resident when they leave the home on a temporary basis and must be complied with.

Specifically, the home failed to comply with the policy, "Self-Medication Administration of Medications" reviewed March 31, 2023, when a resident was provided their medication for self-administration while on Leave of Absences (LOAs).

A resident was found unresponsive upon return from a LOA. The resident would often leave the home unaccompanied on a temporary basis.

The home's policy indicated that prescription medications required by a resident while on LOA from the home were provided in accordance with applicable current legislation in a manner to ensure safe medication administration. This includes Self-Medication Administration Assessment, a physician order for self-administration of medication and a documentation from a nurse on the Medication Administration

Record (MAR) that a resident was on the independent Self-Administration Medication Program.

The resident's progress notes indicated that staff provided the resident their scheduled medication to self-administer while on temporary LOAs. There was no completed assessment or order found in the resident's chart to indicate that they were on an independent self-administration medication program.

An RPN confirmed that they would give the resident their scheduled medication to self-administer while on LOA. An RPN and the ADOC were not able to demonstrate if an assessment was completed or an order for self-medication administration was prescribed for the resident.

There was an increased risk of harm when the resident was not assessed to self-administer medications.

Sources: A resident's paper chart, MAR, assessment records, Policies and Procedures Manual for MediSystem Serviced Homes, home's policy: LTC Self-Administration of Medications, Index: CARE13-010.06 date reviewed March 31, 2023, interviews with RPNs and the ADOC. [723]

WRITTEN NOTIFICATION: Administration of Drugs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that a resident received their medications in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident was reported to have worsening behaviours and their written plan of care indicated staff were to ensure that they received their medication in a timely manner. The resident's Electronic Medication Administration (EMAR) indicated that their medication was not administered or was administered late on several days due to various reasons. A PSW and an RPN confirmed that the resident had increased behaviours when their medication was not administered as scheduled.

Because the home failed to administer the resident's medication as prescribed, the resident had increased behaviours.

Sources: The resident's EMAR, written plan of care, home's investigation notes, and interviews with staff. [723]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (2) (a)
Medication incidents and adverse drug reactions
s. 147 (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents, incidents of severe hypoglycemia, incidents of unresponsive hypoglycemia, adverse drug reactions and every use of glucagon are documented, reviewed and analyzed;

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed.

Rationale and Summary
The home's medication policy indicated that upon discovery of a medication incident, a Medication Incident Report (MIR) would be completed and reviewed quarterly.

Review of the home's submitted MIRs to Medisystem portal and the home's 2023 Professional Advisory Committee (PAC) meeting minutes did not include any documented incident related to a resident's missed and late medication administrations.

An RPN and RN stated that missed medications and late medications were all considered medication incidents and required submission of MIRS in the home's pharmacy portal. The DOC stated that all medications incidents were reviewed during the PAC Meeting.

The ED confirmed that there was no MIR completed related to a resident's medication incidents.

There was an increased risk of medication errors when the resident's medication incidents were not documented, reviewed, and analyzed.

Sources: Policies and Procedures Manual for MediSystem Serviced Homes, PAC Meeting Minutes, 2023 List of Medication Incidents, interviews with an RPN, RN and other staff. [723]