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
Apr 24, 2018	2018_601532_0006	002417-18	Resident Quality Inspection

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

Columbia Forest
650 Mountain Maple Avenue WATERLOO ON N2V 2P7

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

NUZHAT UDDIN (532), APRIL TOLENTINO (218), DOROTHY GINTHER (568), JANETM EVANS (659)

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): March 6, 7, 8, 9, 12, 13, 14, 15, 20, 21, 22, 23, 26, 2018.

The following inspections were conducted concurrently during this inspection:
Log #008252-17, Complaint related to care/assessment.
Log #000608-18, Complaint related to alleged abuse.
Log #001550-18, Complaint related to alleged abuse.
Log #007459-17, Complaint related to care.
Log #011067-17, Critical Incident related to alleged abuse.
Log #007822-17, Critical Incident related to improper transfer.
Log #019079-17, Critical Incident related to neglect.
Log #015350-17, Follow-up to Compliance order #001, #002, #003 from inspection 2017_600568_0003.
Inspector(s) Gloria Kovach #697 and Amanda Coulter #694 joined the RQI team and were onsite March 20, 21, 22, 23, 2018.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Associate Director(s) of Care, Registered Nurses (RN), Food Service Manager, Environmental Service Manager , Recreation and Program Services Manager, Resident Assessment Instrument (RAI) Coordinators, Behaviour Support Ontario Staff (BSO), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping staff, Dietary Aides, Family and Resident Council Representatives, Residents and Family members.

The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures and reviewed medication records as well as hospital clinical records and Community care access center meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **8 WN(s)**
- **7 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_600568_0003	568
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2017_600568_0003	568
O.Reg 79/10 s. 26. (4)	CO #003	2017_600568_0003	568

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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by

initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint was received by the Director related to improper care towards an identified resident.

Record review showed that similar written complaint was also received identifying the same concerns related to improper care.

Clinical record review indicated that resident was on analgesics for pain.

Record review of pain assessment indicated that there were pain assessment completed on two occasions.

Observations noted that the identified resident had a identified device.

Registered Nurse (RN) was asked to observe the identified resident and the RN tried to remove the identified device but had difficulty and the identified resident verbalized pain when the identified device was being removed.

PSW said that the identified resident was exhibiting responsive behaviours and would hold on to the identified device when the staff provided care. PSW said that they inform the nurses regarding pain.

Physiotherapy Assistant (PTA) shared that if a patient mentions anything regarding pain they would assess and tell the Physiotherapist or the nursing staff. PTA said that physiotherapist staff collaborated with nursing staff to ensure that pain was addressed before doing any therapy or exercises with residents however, this was not happening with the identified resident.

The Physiotherapist (PT) acknowledged that the PTA had not communicated with the PT regarding pain. The PT said that they assessed the resident and acknowledged that there were signs of pain during the assessment, however, the pain was never communicated to the registered staff.

Inspector assessed the identified resident at an identified date and the resident verbalized showed signs of pain.

PTA was asked to show Inspector the exercises they performed on the identified resident. They told inspectors that the exercises were primarily passive, they tried to remove the identified device but on initial attempts resident exhibited pain. PTA was not able to remove the device. The identified resident was visibly uncomfortable.

In an interview RN shared that the resident had an order for analgesic for as needed (PRN) basis and the expectation was that the staff notify the registered staff when the resident was experiencing pain but if the RN did not get notified then they would not be able to administer anything for the pain. RN checked the electronic Administration Medication Record (EMAR)s and shared that there was an order for routine analgesics as well as PRN.

Clinical record review of progress notes showed that there was a note documented on a specified date that indicated that resident had verbalized pain.

However, there was no reference as to how the pain was managed and if a pain assessment was done.

Clinical record review of progress note stated that the identified resident had altered skin integrity and had pain.

There was no reference as to how the pain was managed and if a pain assessment was done.

RN acknowledged that this had been present for past several days, they said that they had placed a call to the physician and waiting for a call back and a diagnostic test was ordered.

In an interview ADOC shared that the expectation was that staff treat the pain with appropriate strategies and give PRN medication when they were noticing the pain. The expectation was that PSWs and PTAs would communicate pain if there were signs and symptoms.

During a phone interview ADOC reported that the PSWs were aware of pain and charting it on Point of Care (POC). The ADOC acknowledged that there was no documentation of pain assessment or a note in Progress note (PN) and the night RN verbally reported the concern to the day staff. The ADOC acknowledged that the expectation was that registered staff should have assessed the resident for pain using a clinically appropriate

pain assessment as this was a new pain identified by the resident and the pain assessment was not done.

The licensee failed to ensure that when the identified resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (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. (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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.

Nutrition and Hydration Inspection Protocol for an identified resident triggered through the Resident Quality Inspection indicated no plan and low Body Max Index (BMI).

Record review indicated that the identified resident was offered a nutritional intervention as they were at high nutrition risk.

Observation, showed that the identified resident did not receive their nutritional

intervention as ordered by the dietitian with their meal.

RD explained that there was a decline in the identified resident’s health status which was impacting their intake. Therefore, staff were to provide nutritional interventions.

Nutrition Manager shared that the documentation stated that resident was on nutritional intervention at specified meals. They acknowledged that they spoke to ADOCs and they confirmed that the nutritional intervention was to be given to the identified resident as ordered.

The ADOC confirmed that as per the clinical records and plan of care the nutritional intervention should be given.

The licensee failed to provide the intervention to the resident as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Resident observation through Resident Quality Inspection indicated that resident had an identified device.

Observation indicated that the identified resident had an identified device in place.

Clinical record review indicated that the identified resident had two different types of devices.

Plan of care for the resident identified that they required the use of an identified device to assist with Activities of Daily Living (ADL), however, there was no mention of the device in the plan of care.

The Clinical Coordinator (CC) for BSO acknowledged that there was no documentation made related to the identified device as it was implemented just a day before and shared that there was no progress note, an assessment or a care plan to reflect the change that a device was in place for the identified resident.

RAI Coordinator reported that there was an order from the physician to indicate that resident may have an identified device, however, they verified that this device was initiated just recently again.

Clinical Coordinator acknowledged that the care plan was not revised when the care needs changed for the resident.

The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change. [s. 6. (10) (b)]

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 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 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 the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident Report was submitted to the Director which identified that improper/incompetent treatment of a resident resulted in harm or risk of harm to the resident. The resident sustained an injury.

Record review for the specified resident showed that they required an identified device for ADLs.

In an interview with Personal Support Worker (PSW) they reported that staff were made aware of how to use the safe transferring and devices and techniques for the identified resident located in the kardex.

An identified PSW stated that they were able to explain where to find the technique to be used for a resident's transfer. However, they were unable to recall what type of positioning devices or techniques was used for the identified resident.

Clinical record documented that the identified staff disclosed to using a wrong transferring technique for the specified resident. Clinical record showed the identified resident sustained an injury. There was no documentation of an injury prior to the incident.

In an interview the Director of Care (DOC) explained that the expectation of staff when they notice a change in the resident's ability to transfer was to notify registered staff.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when staff assisted in the transfer of a specified resident. [s. 36.]

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 The licensee shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status.

An identified resident was assessed in the Resident Assessment Instrument (RAI) as having a specified weight change. The identified resident was also assessed to have a chewing problem and leave an identified per cent food uneaten at most meals. It was documented the resident required a mechanically altered and therapeutic diet.

Observations showed that the identified resident had not attended the meal. The resident

was seen later having a snack.

In interviews Personal Support Workers (PSW) and Registered Practical Nurse stated that the identified resident had responsive behaviours and did not always come for meals.

Record review showed that the weight was trending down and the resident was a high nutrition risk.

Review of the clinical record for resident did not show evidence of a referral to the dietitian related to significant weight change. The assessment documented no changes. There was no documented assessment related to the resident's significant weight change.

In an interview Registered Dietitian (RD) stated they saw all high risk residents quarterly. If they received a nutrition care referral they would respond in a progress note. RD stated that they typically reviewed all monthly weights and if there were a significant change they would look at the residents and the interventions that were in place for the resident. The RD acknowledged being aware of the identified resident's weight change and acknowledged there were no referrals made to them. The RD reviewed available documentation and acknowledged that there was no documented nutritional assessment for the identified resident in response to their documented significant weight change.

The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 the licensee shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months
3. A change of 10 per cent of body weight, or more, over 6 months
4. Any other weight change that compromises their health status, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone was available to provide the assistance.

A. The dining observation task was conducted during an RQI on a full meal service on an identified home area.

1. During meal observation it was observed that an identified resident was provided with soup at 1205 hours. There were no staff seated at the table to assist the resident to eat. At 1210 hours Clinical lead sat at the table and started feeding resident but they were observed to assist another resident to eat and cued a third resident. During the meal the identified resident was observed to fall asleep.

Review of the clinical record for the identified resident showed the resident was at high nutritional risk. The resident was documented as below their ideal weight range. The plan of care for the identified resident documented the resident required staff assistance and sometimes needed total assistance with feeding.

2. During a meal observation on an identified home area a specified resident was seen being brought to a table in the dining room at a specified time. The staff member placed a beverage in front of the resident, the identified resident was not able to reach for the beverages. Appetizer was place in front of the identified resident and there was no assistance provided. An identified staff sat down beside the identified resident and started to feed but the food was hot so the identified staff member then left the table and took their stool to another table and began assisting another resident. The identified staff returned to the table and began feeding the identified resident, but after couple of spoonfuls, the staff stood up and began to clear another table of dishes in preparation for the next course. Staff returned to feeding the identified resident after clearing and washing their hands, the resident declined and it was noted that the identified resident declined the second course and to this point the resident had not been assisted with either of their beverages.

Review of resident plan of care identified that the resident required assistance with meals and beverages. (568)

3. Dining observation in an identified home area showed that there were three identified residents sitting at one table and an identified staff member was assisting the residents. It was observed that an identified resident was sleeping while holding on to a beverage. The identified staff was noted to be sitting beside the identified resident but was not assisting the resident. Another identified staff came and removed the beverage cup from the identified resident's hand and served the main course. The identified staff was observed sitting beside the residents but they did not wake or encourage the residents.

At 1253 hours dessert was served to the residents. An identified resident was noted sitting with dessert in front of them but there was no support or assistance provided.

Inspector noted that the dessert had liquefied and another identified resident was consuming the dessert.
RPN walked in the identified dining room and observed the identified resident eating another residents' dessert. RPN stated that the residents need supervision and encouragement. The RPN agreed that the help should be from start of the meal till the

end until dessert was done. They shared that the identified staff should not have left the unit dining room or the residents before notifying a staff member.

In an interview Recreation Manger acknowledged that the expectation for assisting with the meal was to stay from start until the end of the meal after the dessert was served and the residents had eaten.

4. During lunch meal observation, it was noted that an identified resident was sitting in the an identified dining room and was eating their food with their hands. RPN was quietly feeding another resident and was not observed encouraging or assisting the identified resident. Observation showed that the identified resident continued to feed themselves.

Plan of care documented to monitor resident to see if they were actually eating. Cue when necessary to improve eating and at times resident accepted extensive assistance.

Observation showed that the resident was still eating their main course. Clinical Coordinator asked the resident if they wanted assistance with the meal and the resident accepted the offer.

Clinical Coordinator shared that the identified resident often refuses to accept the assistance at the beginning of the meal, but later changes their mind and accept the assistance. Clinical Coordinator acknowledged that there were many residents that required assistance and it was difficult to get to everyone. They shared that they could update the plan of care for the resident to reflect that the resident had responsive behaviours.

A memo from Clinical Coordinator directing registered staff to feed at all meals was noted.

In an interview Clinical Coordinator stated that there were many residents in the home area that required assistance with feeding and they had to distribute the memo as the registered staff do not assist in the dining room with the meal.

The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone was available to provide the assistance. [s. 73. (2) (b)]

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 the licensee shall ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were cleaned, in a good state of repair, and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

A complaint received by the Director related to concerns that residents in the home were being subjected to very high air temperatures.The complainant reported that on they had observed maintenance staff record the air temperature as 39.3 degrees celsius in an identified dining room.The complainant was concerned for the health of residents and stated that this kind of heat could cause dehydration of residents. They said that air temperatures had been a longstanding problem in the home and despite bringing it to their attention on several occasions, including this time, there had been no resolution.

Review of the Air Temperature log for known home area identified that a temperature taken in an identified room was documented as 28.9 degrees celcius.

During an interview with an identified resident, they told an Inspector that sometimes their room was very hot. In an interview another identified resident shared that their room and other areas in the home were often too hot even when it was cold outside. Another identified resident said that the home was aware of the temperature concerns as they had informed them personally and it had been brought forward by a number of residents during Residents' Council meetings over the last few years. The home always says they will look at it but nothing changes.

In interviews with PSW and RPN they said that air temperatures in the home were monitored by maintenance and that they were not able to adjust the temperatures on their own. When asked if the building was kept at a comfortable temperature for residents, they said that maintaining comfortable air temperatures had been a longstanding problem. One area of the home may be cool and another sweltering. They had to open windows and bring in fans to cool things down for residents and their families. Several family members and some residents would complain about the high temperatures as they were concerned about the effect on the residents.

Review of the home's policy titled "Central Heating Air Conditioning Units" index ES E-80 -15 identified under the procedure that heating, ventilation, and air conditioning systems were to be cleaned and in a good state of repair and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

Review of the last semi-annual preventative maintenance report from a contractor completed between identified that they completed an inspection of the Lennox rooftop units, exhaust fans, heat exchanger, and two boilers. It noted that there was some trouble firing one of the boilers due to the building automation system. It was left on manual mode because of problems with this system.

During an interview with the Environmental Services Manager (ESM), they said that they had been working in the home for approximately 15 months and since that time they had been monitoring air temperatures throughout the home on a daily basis and documenting them in a log book. They explained that the home had two heat sources, one from a water radiant system and one from two roof-top heating units. The ESM said that the heat was controlled by an automated system consisting of 53 sensors in the building which relayed temperatures to a controller which would take an average temperature and then adjust the heat delivery by opening and closing valves in different parts of the home. Early in 2017 the ESM said they found out that the automated system was not working as they were getting readings as high as 27 to 28 degrees celsius on one of the floor. It

was determined that the controller was not functioning and many of the valves and sensors were not working. It was unknown how long these items were in disrepair as the ESM said that they did not have a preventative maintenance program for the automated component of their heating system. The rooftop heating units and boilers were inspected semi-annually by Naylor Building Partnerships. In January 2018 they commenced a two phase repair project for the automated side of the system. The repairs are still in progress. The ESM said that they have proposed to their corporate office that once the automated component of their heating system has been repaired, they implement regular preventative maintenance checks.

The licensee has failed to ensure that procedures were developed and implemented to ensure that the home's automated heating system was in a good state of repair, and inspected at least every six months by a certified individual, and that documentation was kept of the inspection. [s. 90. (2) (c)]

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 the licensee shall ensure that procedures are developed and implemented to ensure that the heating, ventilation and air conditioning systems are cleaned, in a good state of repair, and inspected at least every six months by a certified individual, and that documentation was kept of the inspection, to be implemented voluntarily.

WN #7: 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 has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

A. Review of medication incidents were completed as part of the Resident Quality Inspection (RQI).

1. Medication incident for an identified resident was documented.

It was documented that a change in the dose of identified resident drug was documented in the clinical records and on the electronic Medication Administration Record (eMAR). The medication strip packages had not been changed to contain the correct dosage.

Resident was administered an identified drug with an incorrect dosage for a known period of time until the error was discovered.

2. Another medication incident for an identified resident was discovered at a specified date.

Documentation indicated the incident was discovered during shift count and that identified resident was administered another identified resident's drug.

Documentation on the medication incident report indicated that there were no side effects for the identified resident.

B. A complaint report alleged a medication error and possible medication toxicity for an identified resident.

Review of a medication incident for the identified resident documented the medication incident occurred for a known period of time.

The medication incident documented an error of omission where the resident was not administered the identified drug which had been prescribed. The medication incident documented that the resident complained of an increase in their symptoms over the last few days.

In an interview, Director of Care acknowledged that in each of the incidents above, the drugs had not been administered to the residents in accordance with directions for use specified by the prescriber. [s. 131. (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 the licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Review of the medication incidents showed there were number of documented medication incidents. An identified number of medication incidents were selected for review.

A description of the medication incident documented a change in the dose of an identified resident medication. The electronic Medication administration record had been updated to include the new medication dosage. The medication strip packages had not been changed to contain the new medication dosage.

The identified resident was administered the identified medication that had been ordered. This error was repeated from an identified period of the time before it was discovered.

The medication incident documented notifications as appropriate. There was no documentation related to immediate actions taken to assess and maintain the resident’s health.

Review of the clinical record for an identified resident did not show documented evidence of immediate actions taken to assess and maintain the resident's health related to this medication incident.

In an interview, Director of Care (DOC) acknowledged there was no documentation of immediate actions taken to assess and maintain the resident's health.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

2. The licensee has failed to ensure that corrective action was taken as necessary in response to the medication incident for an identified resident.

A review of medication incidents were completed as part of the Resident Quality Inspection (RQI). There were number of documented medication incidents. An identified number of medication incidents were selected for review.

A description of the medication incident documented a change in the dose of an identified resident medication in the quarterly medication review. The electronic medication administration record had been updated to include the new medication

dosage. The medication strip packages had not been changed to contain the new medication dosage.

Review of corrective actions to prevent recurrence showed that the corrective action was not taken as necessary in response to the medication incident for the identified resident.

In an interview three Registered Practical Nurses (RPN) stated that there was no corrective action taken as necessary in response to the medication incident.

In an interview DOC stated that they believed that they had taken the corrective action as necessary in response to the medication incident for the identified resident but they did not. DOC stated they planned to amend how they addressed these medication incidents in the future.

The licensee has failed to ensure that corrective action was taken as necessary in response to the medication incident for identified resident. [s. 135. (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 the licensee shall ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and the licensee shall ensure that corrective action is taken as necessary in response to the medication incident, to be implemented voluntarily.

Issued on this 25th day of April, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), APRIL TOLENTINO (218), DOROTHY GINTHER (568), JANETM EVANS (659)
Inspection No. / No de l'inspection :	2018_601532_0006
Log No. / No de registre :	002417-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 24, 2018
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4
LTC Home / Foyer de SLD :	Columbia Forest 650 Mountain Maple Avenue, WATERLOO, ON, N2V-2P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 52 (2).

Specifically, the licensee shall ensure that when an identified resident and any other resident is experiencing pain that is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

All registered staff must be re-trained on Pain Assessment and Management policy and the expectations of the home as to when to complete the pain assessment. Attendance records are to be maintained for this training.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint was received by the Director related to improper care towards an identified resident.

Record review showed that similar written complaint was also received identifying the same concerns related to improper care.

Clinical record review indicated that resident was on analgesics for pain.

Record review of pain assessment indicated that there were pain assessment completed on two occasions.

Observations noted that the identified resident had a identified device.

Registered Nurse (RN) was asked to observe the identified resident and the RN tried to remove the identified device but had difficulty and the identified resident verbalized pain when the identified device was being removed.

PSW said that the identified resident was exhibiting responsive behaviours and would hold on to the identified device when the staff provided care. PSW said that they inform the nurses regarding pain.

Physiotherapy Assistant (PTA) shared that if a patient mentions anything regarding pain they would assess and tell the Physiotherapist or the nursing staff. PTA said that physiotherapist staff collaborated with nursing staff to ensure that pain was addressed before doing any therapy or exercises with residents however, this was not happening with the identified resident.

The Physiotherapist (PT) acknowledged that the PTA had not communicated with the PT regarding pain. The PT said that they assessed the resident and acknowledged that there were signs of pain during the assessment, however, the pain was never communicated to the registered staff.

Inspector assessed the identified resident at an identified date and the resident verbalized showed signs of pain.

PTA was asked to show Inspector the exercises they performed on the identified resident. They told inspectors that the exercises were primarily passive, they tried to remove the identified device but on initial attempts resident exhibited pain. PTA was not able to remove the device. The identified resident was visibly uncomfortable.

In an interview RN shared that the resident had an order for analgesic for as needed (PRN) basis and the expectation was that the staff notify the registered staff when the resident was experiencing pain but if the RN did not get notified then they would not be able to administer anything for the pain. RN checked the electronic Administration Medication Record (EMAR)s and shared that there was an order for routine analgesics as well as PRN.

Clinical record review of progress notes showed that there was a note

documented on a specified date that indicated that resident had verbalized pain.

However, there was no reference as to how the pain was managed and if a pain assessment was done.

Clinical record review of progress note stated that the identified resident had altered skin integrity and had pain.

There was no reference as to how the pain was managed and if a pain assessment was done.

RN acknowledged that this had been present for past several days, they said that they had placed a call to the physician and waiting for a call back and a diagnostic test was ordered.

In an interview ADOC shared that the expectation was that staff treat the pain with appropriate strategies and give PRN medication when they were noticing the pain. The expectation was that PSWs and PTAs would communicate pain if there were signs and symptoms.

During a phone interview the ADOC reported that the PSWs were aware of pain and charting it on Point of Care (POC).

The ADOC acknowledged that there was no documentation of pain assessment or a note in Progress note (PN) and the night RN verbally reported the concern to the day staff. The ADOC acknowledged that the expectation was that registered staff should have assessed the resident for pain using a clinically appropriate pain assessment as this was a new pain identified by the resident and the pain assessment was not done.

The licensee failed to ensure that when the identified resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

The severity of this area of non-compliance was actual harm. The scope was determined to be isolated and there was a history of one or more unrelated non-compliance in last three year. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 25, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 24th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Nuzhat Uddin

Service Area Office / Bureau régional de services : London Service Area Office