



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et des
Soins de longue durée**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

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Performance Improvement and
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**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 21, May 7, 2014	2014_108110_0004	T-24-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

ELGINWOOD
182 YORKLAND STREET, RICHMOND HILL, ON, L4S-2M9

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

DIANE BROWN (110), SLAVICA VUCKO (210), VERON ASH (535)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): February 11, 12, 13, 14, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 2014.

Additional inspections related to the following LOG#'s were also completed during this inspection:

Log # T-277-14 related to CIS 2869-000006-14.

Log # T-700-13 related to complaint IL-30515-TO and CIS # 2869-000033-13

Log #T-325-14 related to CIS # 2869-000003-14

Log #T-292-14 related to complaint IL-31554-TO

During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of care (ADOC), resident services care coordinator (RSCC), registered dietitian (RD), food service manager, environmental service manager (ESM), resident assessment instrument (RAI) coordinator, program manager registered staff, personal support workers (PSW), dietary aides, cooks, maintenance worker, program aides, family and residents.

During the course of the inspection, the inspector(s) observed resident care, the home's environment, meal and snack service and food production; reviewed resident and home records, policies and procedures; toured all resident homes areas and identified resident rooms; reviewed service reports and policies and procedures.

The following Inspection Protocols were used during this inspection:



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**Accommodation Services - Maintenance
Contenance Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: 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 failed to ensure that a resident with the following weight changes is 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.

Resident #695 is at high nutritional risk, underweight and with a variable intake.

Record review revealed that the resident had a 5 per cent body weight loss over an identified two month period, when the resident's weight decreased by 3.7 kilograms(kg). This weight change further triggered a 7.5 per cent body weight loss over 3 months and a 10 per cent body weight loss over 6 months.

Record review revealed that the resident's physician documented "dietitian to assess weight loss" on an identified date.

Staff interview and record review revealed that the registered staff including the registered dietitian had not assessed the resident's weight loss with actions taken and outcomes evaluated.

2. The licensee failed to ensure a resident with the following weight change is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

- A change of 5 per cent of body weight, or more, over one month.

Resident #672 had a weight loss of 15 per cent body weight over one month. A record review and staff interview confirmed resident's change in weight was not assessed by registered staff including the registered dietitian. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

3. The licensee failed to ensure that a resident with the following weight change is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

- A change of 7.5 per cent of body weight, or more, over three months.

Resident #728 had a weight loss of 7.5 per cent body weight over 3 months. Record review and staff interview confirmed the resident's change in weight was not assessed by registered nursing staff to ensure an interdisciplinary approach, and that actions were taken and outcomes were evaluated. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]



Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector". 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 weight changes, as required above, are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Licensee failed to ensure that the home is a safe and secure environment for its residents.

On an identified date, the inspector observed the presence of multiple portable heaters in various locations throughout the home such as in residents' rooms, corridors, and other common areas.

In an identified room, in an identified home area, the inspector observed a metallic white heater warm to touch between a small wooden table and a wooden, cloth-lined arm chair. The resident door was closed and he/she was asleep in bed. Upon entering the room, the air temperature was hot and dry. The observed conditions presented a fire and burn hazard for the resident.

On the same home area, in an identified room, the inspector observed a gray radiator style portable heater, hot to touch, against the wall directly under the window with the curtains sitting on top of the hot heater. A wooden, cloth-lined arm chair was placed directly in front of the heater. Upon entering the room, the inspector observed that a staff removed the chair to visualize and confirm that the heater was being used in the resident room; however the staff replaced the chair in the same position directly in front of the heater without recognizing that there was a potential fire hazard. The resident was not in the room at the time, and the door was closed. The identified staff member also confirmed that the heater in the room was hot to touch. Radiator style



heaters had the following instructions written on top by the manufacturer "Caution: High temperature, keep electrical cords, drapery and other furnishings at least 3 feet from the front of the heater and away from the side and rear".

An identified maintenance worker and the RAI coordinator confirmed that some models of the portable heaters being used throughout the home were warm and hot to touch. The inspector notified the DOC, the environmental manager, and the administrator regarding the use of various models of portable heaters and the possible fire and burn safety hazards. The majority of portable heaters were provided by the home; however, a few portable heaters were brought into the home for residents use by family members.

Interview with the environmental service manager revealed that sometime in January 2014, the administrator had requested that the radiator style heaters be removed from the home. Interviews conducted with the administrator, environmental manager, and maintenance worker confirmed that they were not aware of the family provided portable heaters operating in the home.

All unapproved family owned and radiator style portable heaters were immediately removed from operation in the home by the director of care and administrator.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #301 was protected from neglect by staff.



Resident #301's plan of care indicated that the resident must be checked daily to ensure he/she was wearing the wandering bracelet at all times, and that he/she is to be supervised when walking in the room and in the hall. The resident is known to wander during the day time, and normally sleeps through the night. The plan of care also included an identified behaviour which described sounds made by the resident.

On an identified date and time, PSW # 1 noticed during rounds that while sleeping, resident #301 was making sounds. With encouragement, the resident was not able to clear the secretion; and the PSW stated that the registered staff was informed and a description of sounds that the resident was making was provided. There was no confirmed documentation of an intervention related to the incident in the resident health record. Three hours later, PSW # 1 checked on the resident who remained asleep but was still making sounds and no further action was taken.

Sometime later that morning, PSW # 2 noticed the resident had gotten out of bed and wandered down the hall unsupervised and sitting in the dining room at a table close to the nurses' desk. The PSW described the sounds the resident was making. The PSW attempted to locate the primary direct care-giver (PSW # 1) who was assigned to care for the resident.

At a later time, the registered staff returned from break and noticed the resident sitting in the dining room at the table close to the nurses' desk. The registered staff described the resident as having sputum in the mouth and clearing the throat. The registered staff stated that they had seen the resident making similar sounds as in the past, and therefore, continued to perform the regular duties of trying to find a staff replacement for the day shift.

Fifty minutes later, PSW # 1 returned to the unit for rounds and found the resident sitting in the dining room at the table close to the nurses' desk. At that time, the PSW described the resident in distress. The registered staff, who was at the nurses' desk, was alerted by PSW # 1 that the resident appeared to be in some distress. At that time, the registered staff gathered the necessary equipment and performed treatment. The registered staff gave directions to PSW # 1 to transfer the resident back to bed immediately while the staff went to another home unit to obtain medical equipment administration to the resident.

The registered staff returned to the resident's room with medical equipment and found the resident unconscious in bed, with a faint pulse initially; then the resident without



pulse. The registered staff and PSWs performed lifesaving measures. The registered staff called 911 and initiated an internal code blue. After the paramedics arrived, the registered staff notified the physician, and the family was contacted and informed of the incident. Twenty-five minutes later, the resident passed away.

A review of staff training records for the home prevention of abuse and neglect of residents program indicated that not all direct care staff completed the training as required for 2013.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that standardized recipes are available for all menus. A review of recipes for week three of the menu cycle revealed 14 standardized recipes for homemade menu items. These recipes were not prepared and replaced with commercially prepared, outsourced products with no corresponding standardized recipe.



A review of recipes revealed recipes with ingredients crossed out, changed from fresh to frozen or added rendering the recipe not standardized. The western frittata recipe included olive oil which was changed for canola oil, fresh sliced green peppers replaced with frozen diced, fresh tomatoes replaced with diced canned, three cheese blend for cheddar cheese, diced ham removed and frozen california vegetables added.

An interview with the food service manager confirmed that changes to the menu from home made recipes to purchased, commercially prepared products were made, in part related to staffing resources and that recipes were not available for the commercially prepared products.

An interview with the home's registered dietitian revealed that she/he was not aware that homemade recipes were replaced with commercially prepared, outsourced products and that her/his approval of the menu was based on the original homemade recipes being followed.

A comparison of a homemade recipe with its substituted, outsourced product revealed that they were not nutritionally equivalent. The substituted product offered less energy and protein per serving than the homemade recipe.

2. The licensee failed to ensure that all menu items are prepared according to the planned menu .

Recipe reviews identified that canned fruit, in natural juice, should be served to all residents including those on diabetic menus. Observations and an interview with the food service manager confirmed that canned fruit in light syrup (added sugar) was regularly purchased and served and that the food service manager was unaware that canned fruit in light syrup contained added sugar. Interview with the home's registered dietitian revealed that canned fruit, in light syrup, should not be served to diabetics and this replacement does not follow the planned menu.

The preparation of turkey sandwiches was observed on February 27, 2014. The recipe directed staff to place 60 grams or four slices of turkey in each sandwich. Staff were observed preparing sandwiches with two to three turkey slices. The inspector requested the weight of three standard slices of turkey. The weight of three turkey slices was 44 grams. The food service manager confirmed the amount of turkey in the sandwich was expected to be 60 grams or four slices.

The menu plan required milk to be offered and served at all three meals. Meals



observations and nursing staff interviews confirmed that milk is not offered at lunch and dinner. A family interview revealed that milk was an expressed beverage preference for their family member, a resident, but juice was regularly served at dinner.

On February 26, 2013, fresh fruit was identified on the breakfast menu. Banana was served to those on a regular diet while an unidentified pureed canned fruit was served to residents on a pureed diet.

The cucumber and red onion salad recipe called for a homemade salad dressing which was replaced with Italian dressing. The salad prepared did not include all ingredients as outlined in the recipe.

The savory meatballs recipe included sautéed onions and red and green peppers which were not included.

Vegetable mixed chunky blend recipe required margarine to be added during the preparation of minced and pureed vegetables, however, margarine was not observed to be added.

Mashed potato recipe required salt to be added; an interview with the cook revealed that he/she does not add salt and that the residents can put salt in themselves. Resident interviews revealed that food is bland.

3. The licensee did not ensure that all food and fluids prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality. Staff interview revealed that poached eggs served from the steamtable, outside the kitchen, have been brought back to the kitchen and used for pureed food. An interview with the food service manager further confirmed that roast beef served from the steamtable, outside the kitchen, has been returned to the kitchen and used for pureed roast beef when roast beef is on the menu. This practice does not support preserving pureed food quality and is not in keeping with the department's policy FSO-D-2- Handling of leftovers. The policy states the following; "any items that have left the main kitchen and/or have been reheated once; and/or have been prepared for minced and puree texture meals, and any mixed salads are discarded."

Observations of food production revealed that frozen vegetables are steamed, cooked and hot held two hours in advance of meal service.

On February 27, 2014 at 2:00p.m., nine bags of frozen vegetables were observed on a cart in the kitchen defrosting when the inspector entered the kitchen. Staff interview



confirmed that the vegetables were to be cooked for dinner meal service. Directions on the package of frozen vegetables state "keep frozen", "do not thaw vegetables before cooking". An interview with the food service manager confirmed that vegetables should be prepared according to the manufacturers instructions and not cooked more than one hour before the meal service.

Resident interviews revealed that vegetables are often overcooked and not hot enough.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are treated with courtesy and respect and in a way that fully recognizes the residents' individuality and respects the residents' dignity.

Inspectors observation confirmed that an identified PSW's interaction with residents during meals did not promote residents' rights to be treated with dignity. The PSW spoke loudly and interacted with confidence and assertion while serving residents' beverages and meals. His/her interaction style was observed to be appreciated by



some residents, however it was met with objections by others as displayed by resident's body language or lack of acknowledgment to the playful gestures or joking behaviors. The PSW performed various interventions for and with residents without first communicating with residents, such as cutting residents food and repositioning a resident in the wheelchair. In general, it was observed that most PSWs were placing bibs on residents without asking if residents required them. One resident removed the bib which was already in place and offered it back to a PSW for another resident who required a bib.

A family interview confirmed similar undignified practices of the identified PSW.

2. The Licensee failed to ensure that every resident has the right to live in a safe and clean environment.

On February 11, 2014, the inspector observed construction work and painting of walls in the hallway of identified rooms. The hallway had a large amount of fine, white dust on the carpet especially directly outside residents' doorways and along the sides of the wall. There were construction workers actively working on the ceilings and walls. One worker started vacuuming the white dust from the carpet, and was wearing a mask. The painter was also wearing a mask since the hallway had a strong odor of paint. There were no devices or equipment in the hallway to contain the dust and the paint odor related to the construction work.

Residents were in close proximity in the lounge and dining room area, however, there were no barriers in place to restrict access to construction area.

Interview with the environmental manager revealed that during a previously supervised visit to the work areas, the workers had barriers in place to prevent residents from entering the area. The manager was unable to explain why the barriers were not in place the day of the inspectors visit. Interview with the environmental manager also confirmed that the reason for the repair work was due to a broken pipe from the sprinkler system resulted in extensive water damage to the Spruce home area. The inspector notified the DOC, the environmental manager, and the administrator of concerns related to the strong odors and large amounts of dry wall dust, both of which could cause respiratory issues for residents.



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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 residents are treated with courtesy and respect and in a way that fully recognizes their individuality and respects the residents' dignity, to be implemented voluntarily.

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

An interview with a PSW and a RPN indicated staff are to follow an incontinent



product list located inside the right door of the clinical charts cupboard. Resident #203 was identified on the list as not requiring incontinence product. An interview with the ADOC and the DOC revealed an updated incontinence products list inside the left door of the cupboard whereby resident #203 was identified as using night pads. Two interviewed PSWs were unaware of the existence of a new updated incontinent care products list.

2. A review of the written plan of care in relation to vision for resident #207 initiated on an identified date, does not give clear direction to staff related to interventions for resident's vision impairment. An interview with RAI MDS coordinator indicated the resident was interested and was able to read small print in newspapers when admitted to the home but later she\he appeared uninterested in reading. An interview with the PSW confirmed staff was still offering newspapers to the resident but they were unaware if the resident was able to read.

3. A review of the continence care plan indicated resident #202 is on prompted voiding/bowel program for incontinence as evidenced by frequently incontinent of bowel and bladder due to impaired cognition. Interviews with regular PSWs revealed a lack of understanding of the intervention "prompted voiding" and how often to offer resident #202 toileting assistance.

4. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A review of the current written plan of care for resident #202's stated the resident exhibits responsive behaviours. In order to decrease the negative behaviours, interventions were described. An interview with the RN identified additional interventions that were not captured in the written plan of care for resident #202. Interview with a PSW revealed an intervention that is taken when resident #202 exhibits specific responsive behaviours. An interview with the RN and other PSWs confirmed they were not aware of these interventions for dealing with resident #202's responsive behavior.

5. A review of the quarterly report and interview with the RN and the DOC revealed



that after medications are reviewed by the registered staff and physician, the quarterly report is sent back to pharmacy. A review of the fax communication received from pharmacy identified a clarification request about resident #202's identified medication. This clarification request was never performed. Record review and an interview with the RN and DOC confirmed resident #202 was given in error an additional 37.5mg of an identified medication.

6. The licensee failed to ensure that resident #204 and #211's substitute decision makers (SDM) have been given an opportunity to participate fully in the development and implementation of the plan of care.

A review of the clinical record for resident #204 indicated that there was a new treatment ordered on five separate occasions. An interview with the RPN revealed that when there is a change in the treatment of a resident, the POA/SDM gets notified and the notification is documented. A review of the clinical record and interview with RPN confirmed the POA of the resident was not notified of the changes in medical treatment.

7. A record review and staff interview confirmed that an eye examination was not performed in 2013. An interview with a family member of resident #211 indicated he/she was not informed in 2013 that an eye specialist was scheduled at the home to perform eye examination, in order to consent for resident #211's examination.

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

Resident #301 had interventions as a result of exit seeking behaviours. The plan of care included observation, documentation of behaviours, and supervision by staff.

During the night shift of an identified date, the resident woke up, left the room and wandered in the hall unsupervised to the dining room, where he/she sat at a table for approximately 5 - 10 minutes before he/she was discovered by staff. Record review and staff interviews revealed that documentation on the resident wandering checklist was incomplete over a specified period of time, including the two night shifts immediately after the resident sustained a serious injury requiring a transfer to the hospital for an assessment.

9. Resident #704's plan of care stated that resident's POA asked program staff to tell



resident to come along for a singing program (which he/she usually accepts), rather than asking resident if he/she would like to go to a program, as resident has a tendency to decline invitations to programs.

A family/POA interview of resident #704 revealed that they have observed resident #704 sitting, not participating in programs, at times when programs were available in the home. The POA expressed his/her preference to include the resident in programming opportunities available.

On an identified date and time, resident #704 was observed sitting alone at a dining table, not participating in a program offered in another area of the home. An interview with the recreation aide revealed that he/she had asked resident if he/she would like to attend an activity and resident said no. The recreation aide confirmed that he/she had not followed the plan of care when inviting resident to an activity program.

10. The licensee failed to ensure that resident #212's plan of care is reviewed and revised when the resident's care needs changed.

A review of the written plan of care for resident #212 in relation to wound management from an identified month in 2013, indicated interventions from an identified month in 2011 related to alteration in skin integrity due to injury. These interventions were not currently in effect. Furthermore, a review of the clinical record indicated resident #212 came back from hospital with surgical wound and acquired pressure ulcer on an identified date. Resident #212 was not re-assessed and the written plan of care was not reviewed and revised when the resident's care needs changed in an identified month in 2013, when the resident returned from hospital.

11. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

Record review and staff interviews confirmed that resident #666 was not assessed by a registered dietitian after readmission to the home after undergoing surgery. Health record review confirmed that the resident was not eating or drinking since return from hospital. The home's Nutrition Referral Form and Nutritional Assessment and Care Policy # LTC-G-50 indicates that a referral is to be made to the registered dietitian if the resident has poor food intake of less than 50% consumption for three consecutive days, poor fluid intake of less than 75% assessed for three consecutive days or



showing signs/symptoms of dehydration, poor compliance to therapeutic diet, and readmission from the hospital. Furthermore, the policies direct staff to complete a written referral or an electronic referral in Point Click Care to the registered dietitian, and the RD will make nutritional recommendations once an assessment and interview with the resident is completed. Staff interviews revealed that the RD assesses residents only after the physician writes an order requesting a RD assessment, which is not consistent with the home's policy.

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 plan of care sets out clear directions to staff and others who provide direct care to residents; that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).

(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A review of the home's policy "Skin and Wound Care Program", LTC-E-90, revision date August 2012, section, "referrals" states "refer to physiotherapy, occupational therapy, registered dietitian, entherostomal therapist (ET), and \or other interdisciplinary team members as required".



A review of the policy "The interdisciplinary wound care team" , LTC-E-90, Appendix A, describes the roles and responsibilities of the interdisciplinary members. The role and responsibilities of the registered dietitian was described as: reviews the monthly skin integrity report, conducts a nutritional assessment for all residents with skin breakdown and makes recommendations for a nutritional treatment plan for the residents when necessary, monitors resident's nutritional status, communicates changes to the team by updating the resident's care plan to reflect nutritional needs, initiates nutritional orders for nutritional treatment if necessary.

This policy is not in compliance with the Long Term Care Act, 2007, s. 50 (2) (b)(iii) that indicates "a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident' plan of care relating to nutrition and hydration are implemented" as it does not clarify what "as required" means in order for a referral to be sent to the registered dietitian or what "when necessary" means for the registered dietitian to conduct a nutritional assessment for all residents with skin breakdown.

2. A review of the home's policy "pain assessment and symptom management" LTC-E-80, revision date August 2012, states instruments utilized to assess pain are: self-reporting, visual analogue scale-VAS LTC-E-80 appendix A, faces pain scale (FPC) LTC-E-80 appendix B, doloplus 2 scale LTC-E-80 appendix D, pain assessment checklist for seniors with limited ability to communicate (PACSLAC) LTC-E-80 appendix E.

A record review indicated when resident #212 returned from hospital on an identified date, he/she was assessed for pain by the nurse and the assessment was documented on the Pain Flow Sheet form. Furthermore, on the same form, it was written that the resident was not able to give a description of the pain. Resident's plan of care identified him/her as cognitively impaired. An interview with a RN indicated that staff are not aware that there is a Visual Assessment Scale (VAS) form for the pain assessment of cognitively impaired residents. An interview with the ADOC confirmed there is a VAS form used for a pain assessment of cognitively impaired residents located in the pain assessment binder on every unit. The ADOC confirmed that the VAS form was not used for resident #212's pain assessment as required. The policy for "pain assessment and symptom management" was not complied with.



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 the homes' policy Skin and Wound Care Program is in compliance with the LTCHA, to be implemented voluntarily.

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17.
Communication and response system**

Specifically failed to comply with the following:

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**

(b) is on at all times; O. Reg. 79/10, s. 17 (1).

(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).

(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).

(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).

(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system was available at each bed location used by residents.

On an identified date, at resident #102's bed, there was no resident-staff communication and response system observed. An interview with a registered staff confirmed the absence of a resident-staff communication and response system at residents bed location and that resident #102 was able to yell for assistance and that staff conducted hourly rounds.



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 home is equipped with a resident-staff communication and response system is available at each bed, to be implemented voluntarily.

WN #9: 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:

4. Vision. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,

(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).

(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the plan of care is based on an interdisciplinary assessment of resident #207, #211, and #212's vision.

A review of the latest RAI MDS assessment indicated that resident #207's vision was moderately impaired. An interview with the RAI coordinator indicated that residents with cognitive impairment are not referred to an eye specialist for vision assessment because they do not know how the assessment would be performed. An interview with the RPN and a review of the clinical record indicated that resident #207 was not assessed by an eye specialist for impaired limited vision.

2. A review of the latest RAI MDS assessment of an identified date, indicated resident #211 has impaired vision. Interview with an identified staff indicated resident #211 was interested in watching TV and reading but staff were unable to confirm if the resident's



impaired vision impacted his/her disinterest in watching TV and reading. A review of the clinical record and interview with a family member indicate there was no interdisciplinary assessment for the resident's impaired vision.

3. A review of the RAI MDS assessment of an identified date, revealed resident #212 had moderately impaired - limited vision. A review of the current written care plan does not include an interdisciplinary assessment of resident's vision.

A review of the written plan of care indicated resident #212 had impaired vision and a consultation with eye care practitioner to be arranged. An interview with the resident's POA confirmed there was no interdisciplinary assessment for the resident's impaired vision.

4. The licensee failed to ensure that the registered dietitian who is a member of the staff of the home assess resident's nutritional status, including height, weight and any risks related to nutritional care.

Resident #672 had a nutritional risk related to a significant unplanned weight loss of 16% over an identified period of time. Documentation revealed that the resident was identified with a stage 2 coccyx ulcer on an identified date. Record review and an interview with the registered dietitian revealed that resident #672's energy needs are a component of the nutritional assessment, however residents estimated nutritional needs were not compared with estimated nutritional intake. As a result, it was unclear to the registered dietitian if adequate energy to compensate for unplanned weight loss and maintenance of goal weight, as identified in her/his plan of care, was being offered.

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 the plan of care is based on an interdisciplinary assessment of resident's with impaired vision, to be implemented voluntarily.

WN #10: 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,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
O. Reg. 79/10, s. 50 (2).

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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #212, exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon return from hospital.

A review of the clinical record and an interview with the RN and the DOC indicated resident #212 returned from hospital on an identified date, and he/she had an incision wound identified. A skin assessment was not completed for the resident by registered nursing staff upon the return from hospital.



2. The licensee failed to ensure that resident #212 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, has 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.

An interview with a RN confirmed that after identifying skin problem, stage 1, red areas to stage 4, open areas, a skin assessment is completed and documented on the Initial Wound Assessment-Treatment Observation Record and on the Ongoing Assessment/Treatment Observation Record forms.

Resident #212's clinical record identified him/her at high risk for skin breakdown related to decreased mobility after returning on an identified date, from the hospital for surgery.

A review of the clinical record for resident #212 revealed that on an identified date, a RN documented a large blister on resident's heel in the progress notes. A further review of the resident's clinical record and an interview with the RN confirmed that when the RN documented the skin blister in progress notes on an identified date, a skin assessment using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was not performed until seven days later.

Over a seven month period, resident #212's wound advanced, was healing and continued to be treated.

The DOC confirmed through interview that the RN who documented the presence of a skin blister on an identified date, did not take the appropriate action for skin and wound management which included an assessment using a clinically appropriate assessment instrument.

3. The licensee failed to ensure that resident #212 exhibiting altered skin integrity, including skin pressure ulcers, received immediate treatment and interventions to promote healing as required.

A review of the clinical record indicated that registered staff documented a blister on the heel of resident #212 on an identified date. On the following day, the physician prescribed booties to be worn on both feet at all times in order to promote healing of the blister. A review of the electronic Treatment Administration Record (e-TAR) and



an interview with the RN confirmed the treatment was not implemented immediately as ordered but began four days later.

4. The licensee failed to ensure that resident #212 and resident #672 exhibiting altered skin integrity, including pressure ulcers, or wounds have been assessed by a registered dietitian who is a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration been implemented.

A review of the clinical record indicated resident #212 came back from the hospital on two identified dates, acquired a Stage 2 pressure ulcer on heel. An interview with RD confirmed he/she was not notified about the pressure ulcer until the following month, in order to assess resident #212's nutritional needs related to his/her altered skin integrity. [s. 50. (2) (b) (iii)]

5. Record review indicated resident #672 had a Stage 2 ulcer on his/her coccyx on an identified date, and Stage 2 open area on his/her coccyx on an identified date, which were not assessed by the registered dietitian. Staff interviews and record review confirmed that a referral to the registered dietitian was not initiated.

6. The licensee failed to ensure that resident #212 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

A review of the clinical record indicated resident #212 was re-admitted from the hospital on an identified date, with an incision wound after surgery. Further, the clinical record indicated on an identified date, he/she acquired a Stage 2 pressure ulcer on the heel. A review of the e-TAR revealed the resident continued to be treated for the heel wound and toe blister. A review of the clinical record for resident #212 and an interview with the RN confirmed that a weekly wound assessment was not performed for a period of identified weeks.

7. The license failed to ensure that resident #212, who was dependent on staff for repositioning, has been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

A review of the clinical record indicated on an identified date, resident #212 came back from the hospital after injury and surgery. On an identified date, the



physiotherapist (PT) performed an assessment and identified the resident at risk for complications due to decreased mobility and lack of motivation to get out of bed. A RAI MDS assessment on an identified date, indicated resident #212 required extensive assistance by two people for bed mobility, turning and repositioning in bed. An interview with a PSW indicated that when residents require assistance for turning and repositioning in bed, the performed care is documented in flow sheets. This practice was confirmed through reviewing the skin and wound care program policy. A record review revealed the absence of no flow sheets indicating resident had been turned and repositioned every two hours or more frequently as required. Record review indicated weeks later, on an identified date, resident #212 acquired a Stage 2 pressure ulcer on the heel.

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 residents exhibiting altered skin integrity receive the following: a skin assessment by a member of the registered nursing staff upon return from hospital; 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; assessed by a registered dietitian who is a member of the staff of the home and receive immediate treatment and interventions to promote healing as required, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours



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Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).

(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :



1. The licensee failed to ensure that strategies have been implemented to respond to the resident demonstrating responsive behaviors.

An interview with a PSW and a RN indicated an unawareness of the individualized recommended strategy for resident #202 to reduce his/her responsive behaviours. Staff confirmed that the identified strategy is not implemented on an everyday basis but only at group program activities. A review of the clinical record indicated that on an identified date and meal, an altercation occurred in the dining room between resident #202 and another resident. According to a report it was documented that "the other resident was pushed down to the floor and sustained some scratches and a bump on the head" from an altercation with resident #202.

2. The licensee failed to ensure that actions are taken to meet the needs of resident #202 and #201 with responsive behaviors including reassessments and documentation of the residents' responses to the interventions.

A review of the clinical record indicated resident #201 had a history and recent increase in responsive behaviour. On an identified date, the physician ordered an intervention to monitor resident #201 for a prescribed period of time, using a specific assessment instrument, Dementia Observation System(DOS). Staff interview and a review of the DOS report of the prescribed dates confirmed incomplete documentation of the DOS report.

3. A review of the clinical record indicated resident #202 had a history and recent increase in responsive behaviours. On an identified date, the physician ordered monitoring for a prescribed period of time of resident #202 for responsive behaviours, using an assessment instrument DOS. Monitoring of resident #202 was not initiated until two days later, and the documentation of resident's responses to the interventions was incomplete for three of the prescribed monitoring period.



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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 strategies have been implemented to respond to the resident demonstrating responsive behaviors, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :



1. The licensee failed to respond in writing within 10 days of receiving the Residents' Council advice related to concerns or recommendations.

An interview with the president of the Residents' Council revealed that written responses are not provided to the Residents' Council when the council advises the licensee of concerns or recommendations and that the licensee does not respond to the council within 10 days.

A review of December 10, 2013, Residents' Council meeting minutes identified the following concerns:

- "Shower and spa rooms are too cold and that residents would like the heat to be turned up."
- "Residents had brought up call bells and that they need to be answered sooner and they have been taking too long and that is not good."
- "Residents on Hickory Lane are not all wearing cloth protectors, resident would like staff to be reminded to make sure all residents are wearing the cloth protectors".

An interview with the resident services care coordinator and administrator confirmed that a written response to the concerns expressed at the December 10, 2013, Residents' Council meeting was not provided to council.

The homes' food committee is part of the Residents' Council. A review of food committee meeting minutes and an interview with the food services manger confirmed that the concerns and recommendations brought forward at the food committee meeting are not responded to in writing within 10 days of receiving them. [s. 57. (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 a response in writing within 10 days of receiving the Residents' Council advice related to the concerns or recommendations is provided to the Residents' Council, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning



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Specifically failed to comply with the following:

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).**

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :



1. The licensee failed to ensure that the menu cycle was approved by a registered dietitian who is a member of the staff of the home.

A review of the menu and staff interviews revealed that the home's menu was changed from homemade recipes to many commercially prepared, outsourced products. Week three of the menu cycle identified 14 homemade recipes that were substituted with commercially prepared, outsourced menu items. An interview with the home's registered dietitian revealed that she/he was not aware that homemade recipes were replaced with commercially prepared, outsourced products and that her/his approval of the menu was based on the original homemade recipes being followed.

A comparison of a homemade recipe with its substituted, outsourced product revealed that they were not nutritionally equivalent. The substituted product offered less energy and protein per serving than the homemade recipe. The registered dietitian confirmed that the nutrient analysis reviewed as part of her/his menu approval is based on the original menu with homemade recipes not based on the substituted outsourced products. The menu cycle in place was not approved by a registered dietitian, who is a member of the staff of the home.

A review of the "menu approval and review tool" completed by the registered dietitian to approve the home's menu included recommendations and comments. Observations and staff interviews confirmed that these recommendations were not implemented. An interview with the home's registered dietitian revealed that the menu is approved with the implementation of the recommendations and comments therefore the menu in place was not the approved menu by the registered dietitian, who is a member of the staff of the home.

2. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack. Resident #672, at high nutritional risk related to unplanned weight loss was observed at a meal on an identified date. This resident required total feeding assistance, and was fed oatmeal and tea by a student. Once the resident completed his/her oatmeal, the student was directed to assist another resident at another table. The PSW, student's mentor, stated, when interviewed that meal service was finished and revealed that resident #672 had been served an entrée. Observations and student interview confirmed an entrée had not been served to this resident. The resident was served the entrée, after the issue was identified by inspector, and consumed 100 percent of the meal provided.



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 menu cycle was approved by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed, no later than one business day after the occurrence of the incident as per s. 107(3)4.

Record review confirmed that the home did not report to the Director no later than one (1) business day, that resident # 717 fell in the room on identified date, which resulted in the resident's admission to hospital with surgical intervention. The home was made aware of the fracture and the need for surgery on an identified date, at approximately, by the resident's POA. Critical Incident Report was submitted to the Ministry nine days after the injury.

2. Record review confirmed that the home did not report to the Director no later than one (1) business day, that resident # 666 fell in the room on an identified date, which resulted in the resident's admission to hospital with surgical intervention for a fracture. The home was made aware of the fracture and the need for surgery on an identified date, by the resident's POA. Critical Incident Report was submitted to the Ministry eight days after the injury.



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 Director is informed, no later than one business day after the occurrence of the incident as per s. 107(3)4, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 120.

Responsibilities of pharmacy service provider

Every licensee of a long-term care home shall ensure that the pharmacy service provider participates in the following activities:

- 1. For each resident of the home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.**
- 2. Evaluation of therapeutic outcomes of drugs for residents.**
- 3. Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.**
- 4. Developing audit protocols for the pharmacy service provider to evaluate the medication management system.**
- 5. Educational support to the staff of the home in relation to drugs.**
- 6. Drug destruction and disposal under clause 136 (3) (a) if required by the licensee's policy. O. Reg. 79/10, s. 120.**

Findings/Faits saillants :



1. The licensee failed to ensure that the pharmacy service provider participates in the maintenance of medication profiles for each resident of the home.

Staff interviews and a record review revealed that the home changed from paper charting to electronic charting in March 2013. A review of resident # 695's medication administration record (MAR) revealed that during the transition from paper to electronic MAR (e-MAR) in March 2013, Classic Care Pharmacy, did not enter the previously ordered, identified nutritional supplement three times a day at Med-Pass into the resident's medication profile. Staff interview confirmed that the registered staff and PSWs continued to administer the nutritional supplement with meals, however the original physician order for nutritional supplement was not reinstated into the e-MAR until thirteen months later, after it was identified by the inspector.

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 pharmacy service provider participates in the maintenance of medication profiles for each resident of the home, to be implemented voluntarily.

WN #16: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

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

A review of the e-MAR of an identified month, indicated resident #202 was prescribed, by the physician, 50 mg of an identified medication, 1/4 medication (12.5mg) twice daily as needed (PRN) for an identified condition. A clinical record review indicated the resident received the identified medication of 50mg as PRN, four times the prescribed dosage on four identified occasions. Staff interview confirmed this incorrect dosage was a medication error.

2. The inspector observed and staff interview confirmed that staff administered prescribed drugs to residents based on individual staff preference versus as medication prescribed in the resident's e-MAR, as demonstrated in the following examples; the registered staff crushed resident #304 medication contrary to the e-MAR statement to give whole pills with water; registered staff poured and administered unmeasured amounts of an identified nutritional supplement ordered in measured doses by the physician and registered dietitian and administered to residents #'s 302, 303, 304, and 305; as well, registered staff stated that the decision to administer prescribed liquid nutritional supplement to resident #303 was based on whether the resident completes the meal served or not, which is contrary to the prescribed order.

An interview with the director of care confirmed that registered staff are required to measure and administer the prescribed amount of 2 Cal supplement as ordered by the dietitian and the physician.

3. Record review and staff interviews confirmed that resident #695 was prescribed an order for a nutritional supplement, three times a day, over a thirteen month period. Staff interviews confirmed that the home changed from paper charting to electronic charting, including medication administration records, in March 2013. Record review and staff interviews confirmed that over an eleven month period, the physician's order for an identified nutritional supplement, three times a day was not documented, on e-MAR, as given.

4. The Licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.



On an identified date, the inspector observed and resident and staff interview confirmed that registered staff poured the prescribed medication for resident #306 at meal time and left the medication in the dosing cup sitting on the table in front of the resident so that the resident may take the medications when it is convenient.

The inspector confirmed with the director of care that staff are expected to administer medication to the resident and supervise medication ingestion before leaving, to ensure medication is being taken as prescribed and to prevent other residents from taking non-prescribed medication.

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 residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training and retraining at times and intervals provided for in the regulation, in falls prevention and management and skin and wound care.

A review of the staff training record indicated that not all direct care staff completed the training as required for 2013.

An interview with the DOC confirmed that 90% of all direct care staff received the training in falls prevention and management.

2. An interview with the ADOC confirmed 72% of all direct care staff received the training in skin and wound care, whereby the DOC confirmed 87%.

An interview with the DOC indicated the training for skin and wound care is mandatory for full time staff to attend once a year but not for casual staff.

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training and retraining at times and intervals provided for in the regulation, in falls prevention and management and skin and wound care, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

**s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).**

s. 229. (2) The licensee shall ensure,



(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,

(a) infectious diseases; O. Reg. 79/10, s. 229 (3).

(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).

(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).

(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).

(e) outbreak management. O. Reg. 79/10, s. 229 (3).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

3. Residents must be offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the Infection Prevention and Control (IPAC) program is evaluated and updated at least annually in accordance with evidence-based practices.

A review of the IPAC yearly data collected in 2013, presented at the Professional



Advisory Committee (PAC) meeting on January 23, 2014, the Annual Program Evaluation (Ontario) dated August 30, 2013, and the monthly IPAC data for December 2013, and January 2014, did not include all of the types of resident infections, including UTI, respiratory, ESBL, eye infections, wound infections in accordance with evidence based practices. An interview with the ADOC revealed he/she was not able to confirm further evaluation of the IPAC program including all infection types.

2. The licensee failed to ensure that a written record of the annual IPAC program evaluation is kept that includes the names of the persons who participated. A review of the IPAC program evaluation form and interview with the ADOC indicated the program was evaluated by the ADOC on August 30, 2014, furthermore the ADOC confirmed that the DOC and ED also participated but their names were not documented as required.

3. The licensee failed to ensure that the designated staff member who co-ordinates the infection prevention and control program has education in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

The ADOC, the designated staff member who coordinates the IPAC program, was unable to demonstrate that he/she has education in infection prevention and control practices including the infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

4. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On identified dates, during medication passes, the inspector observed that three out of four registered staff did not practice hand hygiene before or after administration of medication between residents, after contact was made with another resident.

During meal observation on an identified date, the inspector observed that direct care staff who fed multiple residents did not perform hand hygiene between residents in the dining room.

An interview with the director of care confirmed that the expectation is direct care staff and registered staff to sanitize their hands before and after contact is made with residents by using the hand sanitizers provided or by washing their hands when



appropriate.

5. The licensee failed to ensure that the information gathered on every shift about the residents' infections, was analyzed daily to detect the presence of infection and reviewed at least monthly to detect trends for the purpose of reducing the incidence of infections and outbreaks.

An interview with the ADOC revealed that he/she collects infection data from laboratory reports, but he/she was unable to present a review of the monthly data detecting trends for the purpose of reducing the incidence of infections.

6. The licensee failed to ensure that there is a hand-hygiene program with access to point-of-care hand hygiene agents.

Observations of resident's rooms and an interview with the ADOC confirmed hand hygiene agents are not accessible at the point of care in resident rooms. An interview with the ADOC revealed the expectation is staff to use the sink in resident's washroom in order to clean their hands. This practice is not considered at point of care hand hygiene as per provincial infectious diseases advisory committee (PIDAC) guidelines.

7. The licensee failed to ensure that residents are offered immunizations against pneumococcus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

An interview with the ADOC indicated pneumovax vaccine is only given to a resident if the physician orders it and it is not offered to all residents. A record review and staff interview revealed resident #220 signed a consent for pneumovax vaccine at admission on the "Consent to care and treatment-wellness maintenance program" form, but the immunization was not given to the resident. The ADOC confirmed the consent form is in place but the pneumovax vaccine was not given.

Furthermore, an interview with ADOC revealed that residents are not offered tetanus and diphtheria immunization.



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 Infection Prevention and Control (IPAC) program is evaluated and updated at least annually in accordance with evidence-based practices, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).

(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).

(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :



1. The licensee failed to ensure that the resident's SDM is given an opportunity to fully participate in the care conference.

A review of the clinical records indicated the interdisciplinary care team meeting for resident #204 was scheduled on an identified date. Interview with the RSCC indicated the yearly care conferences are usually held at the same month of admission each year. The POA or designated family member is called one month in advance to be notified about the tentative care conference date. If the family member does not call back, the RSCC calls the POA again to confirm ability for attendance or to reschedule another date. The home left a message for the resident's POA on an identified date in advance of the care conference, but was never called again to confirm the availability for attendance. The interdisciplinary team continued with the care conference without the POA. An interview with the POA revealed that they were unaware of the care conference being held and they expressed concern about the home proceeding with the care conference without confirming with the POA.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (2) If there is no Family Council, a family member of a resident or a person of importance to a resident may request the establishment of a Family Council for a long-term care home. 2007, c. 8, s. 59. (2).

s. 59. (3) The licensee shall assist in the establishment of a Family Council within 30 days of receiving a request from a person mentioned in subsection (2). 2007, c. 8, s. 59. (3).

**s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

Findings/Faits saillants :



1. The licensee failed to assist in the establishment of a Family Council at the request of the family member of a resident or person of importance to a resident in the home.

Staff interviews and record review revealed that the home does not have an established Family Council.

An interview with the administrator revealed that there were no family members who had expressed interest in the establishment of a Family Council.

An Interview with the RSCC, revealed that a family member of a resident did approach her last year with interest to participate in a Family Council. The RSCC confirmed that he/she was not going to have a council meeting with one family member.

2. The licensee failed to assist in the establishment of a Family Council within 30 days of receiving a request of the family member of a resident or person of importance to a resident in the home.

An interview with the RSCC, revealed that a family member of a resident did approach her last year with interest to participate in a Family Council. The RSCC confirmed that he/she was not going to have a council meeting with one family member.

3. The licensee failed to ensure that with no established Family Council the license convene semi-annual meetings to advice residents' families and persons of importance to residents of their right to establish a Family Council.

An interview with the administrator, the RSCC and record review revealed that the last meeting held to advice residents' families and persons of importance to residents of their right to establish a Family Council was on April 16, 2012.

WN #21: 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. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :



1. The licensee did not ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council. An interview with the president of the Residents' Council and the administrator confirmed that meal and snack times have not been reviewed by the Residents' Council.

2. The licensee did not ensure food and fluids are served at a temperature that is both safe and palatable to the residents.

On an identified date, resident #101 was observed being served a cup of tea at the morning snack pass and expressed concern that his/her tea was not hot. The temperature of the tea was taken and was 48 degrees Celsius. Policy review and staff interview confirmed that hot beverages should be served at a minimum of 60 degrees Celsius.

On an identified date, the temperature of a hot entrée was taken. The macaroni and cheese was 50 degree Celsius and held in a shallow foil pan in the top section of the steam table. Record review and staff interviews revealed the temperature standard for hot food is a minimum of 60 degrees Celsius.

Resident interviews identified that food and hot beverages are not always hot enough.

3. The licensee failed to ensure that proper feeding techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On an identified date, during the afternoon snack pass, in an identified home area a resident was observed leaning back in his/her chair at approx 70 degree with his head in view of the ceiling while an identified staff assisted resident by feeding him/her a drink. Resident was heard and seen coughing after staff poured drink into resident's mouth. An interview with the registered nurse supervising, who minutes later observed the residents position, stated "no one would feed a resident in that position; it is not a safe position for feeding".

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 245.

Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,
 - i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and
 - ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.
2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.
3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.
4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.
5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.
6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.
7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.
8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :



1. The licensee failed to ensure that residents are not charged for anything the licensee must ensure is provided to a resident under the Regulation, unless a charge is expressly permitted.

Resident #695, at high nutritional risk, has a plan of care that included a physician's order for a nutritional supplement, to be provided three times a day. Record review and family interview confirmed that resident #695's family have been paying for and providing the nutritional supplement to the home for four to five years, since the resident's admission. An interview with the administrator revealed that he/she was unaware the family was purchasing the supplement and confirmed that the home should be providing it to the resident.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

Table with 4 columns: REQUIREMENT/ EXIGENCE, TYPE OF ACTION/ GENRE DE MESURE, INSPECTION # / NO DE L'INSPECTION, INSPECTOR ID #/ NO DE L'INSPECTEUR. Row 1: O.Reg 79/10 s. 69, CO #901, 2014_108110_0004, 110

Issued on this 17th day of June, 2014

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



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

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*

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*

**Health System Accountability and Performance Division
Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité**

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : DIANE BROWN (110), SLAVICA VUCKO (210), VERON
ASH (535)

Inspection No. /

No de l'inspection : 2014_108110_0004

Log No. /

Registre no: T-24-14

Type of Inspection /

Genre d'

inspection:

Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Feb 21, May 7, 2014

Licensee /

Titulaire de permis :

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA,
ON, L5R-4B2

LTC Home /

Foyer de SLD :

ELGINWOOD
182 YORKLAND STREET, RICHMOND HILL, ON, L4S-
2M9

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur :

DIAN CAIRNS



**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*

**Ministère 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*

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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 : 901

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. 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.

Order / Ordre :

The licensee must ensure that resident #695's weight loss is assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

Grounds / Motifs :



**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*

**Ministère 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*

1. The licensee failed to ensure that a resident 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.

Resident #695 is at high nutritional risk, underweight and with variable intake. Record review reveals that resident had a 5 per cent body weight loss over an identified two month period when resident's weight decreased by 3.7kilograms. This weight change further triggered a 7.5 per cent body weight loss over 3 months and a 10 per cent body weight loss over 6 months.

Record review revealed that resident's physician documented "dietitian to assess weight loss" on an identified date.

Staff interview and record review revealed that the registered staff including the registered dietitian had not assessed resident's weight loss with actions taken and outcomes evaluated.

(110)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Immediate



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*

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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee shall prepare and implement a plan to ensure that that the home is a safe and secure environment for its residents.

This plan shall include measures to ensure the safe use of all portable heaters throughout the home.

The plan shall be submitted to Diane.Brown@ontario.ca by May 16, 2014

Grounds / Motifs :

1. The Licensee failed to ensure that the home is a safe and secure environment for its residents.

On an identified date, the inspector observed the presence of multiple portable heaters in various locations throughout the home such as in residents' rooms, corridors, and other common areas.

In an identified room, in an identified home area, the inspector observed a metallic white heater warm to touch between a small wooden table and a wooden, cloth-lined arm chair. The resident door was closed and he/she was asleep in bed. Upon entering the room, the air temperature was hot and dry. The observed conditions presented a fire and burn hazard for the resident.

On the same home area, in an identified room, the inspector observed a gray radiator style portable heater, hot to touch, against the wall directly under the window with the curtains sitting on top of the hot heater. A wooden, cloth-lined arm chair was placed directly in front of the heater. Upon entering the room, the inspector observed that a staff removed the chair to visualize and confirm that the heater was being used in the resident room; however the staff replaced the



**Ministry of Health and
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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*

**Ministère 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*

chair in the same position directly in front of the heater without recognizing that there was a potential fire hazard. The resident was not in the room at the time, and the door was closed. The identified staff member also confirmed that the heater in the room was hot to touch. Radiator style heaters had the following instructions written on top by the manufacturer "Caution: High temperature, keep electrical cords, drapery and other furnishings at least 3 feet from the front of the heater and away from the side and rear".

An identified maintenance worker and the RAI coordinator confirmed that some models of the portable heaters being used throughout the home were warm and hot to touch. The inspector notified the DOC, the environmental manager, and the administrator regarding the use of various models of portable heaters and the possible fire and burn safety hazards. The majority of portable heaters were provided by the home; however, a few portable heaters were brought into the home for residents use by family members.

Interview with the environmental service manager revealed that sometime in January 2014, the administrator had requested that the radiator style heaters be removed from the home. Interviews conducted with the administrator, environmental manager, and maintenance worker confirmed that they were not aware of the family provided portable heaters operating in the home.

All unapproved family owned and radiator style portable heaters were immediately removed from operation in the home by the director of care and administrator.

(535)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : May 30, 2014



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*

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 : 002

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are not neglected by the licensee or staff.

The plan should include but not limited to the following:

- 1) Training for staff in the prevention of neglect of residents.
- 2) Strategies to ensure staff take immediate action to address significant changes in residents' health status.

Please submit the plan to Diane.Brown@ontario.ca on or before May 16, 2014

Grounds / Motifs :

1. The licensee failed to ensure that resident # 301 was protected from neglect by staff.

Resident #301's plan of care indicated that the resident must be checked daily to ensure he/she was wearing the wandering bracelet at all times, and that he/she is to be supervised when walking in the room and in the hall. The resident is known to wander during the day time, and normally sleeps through the night. The plan of care also included an identified behaviour which described sounds made by the resident.

On an identified date and time, PSW # 1 noticed during rounds that while sleeping, resident #301 was making sounds. With encouragement, the resident was not able to clear the secretion; and the PSW stated that the registered staff was informed and a description of sounds that the resident was making was provided. There was no confirmed documentation of an intervention related to the incident in the resident health record. Three hours later, PSW # 1 checked on the resident who remained asleep but was still making sounds and no further action was taken.

Sometime later that morning, PSW # 2 noticed the resident had gotten out of bed and wandered down the hall unsupervised and sitting in the dining room at a table close to the nurses' desk. The PSW described the sounds the resident was making. The PSW attempted to locate the primary direct care-giver (PSW # 1) who was assigned to care for the resident.

At a later time, the registered staff returned from break and noticed the resident sitting in the dining room at the table close to the nurses' desk. The registered staff described the resident as having sputum in the mouth and clearing the throat. The registered staff stated that they had seen the resident making similar sounds as in the past, and therefore, continued to perform the regular duties of trying to find a staff replacement for the day shift.

Fifty minutes later, PSW # 1 returned to the unit for rounds and found the resident sitting in the dining room at the table close to the nurses' desk. At that time, the PSW described the resident in distress. The registered staff, who was at the nurses' desk, was alerted by PSW # 1 that the resident appeared to be in some distress. At that time, the registered staff gathered the necessary equipment and performed treatment. The registered staff gave directions to PSW # 1 to transfer the resident back to bed immediately while the staff went to another home unit to obtain medical equipment administration to the resident.

The registered staff returned to the resident's room with medical equipment and found the resident unconscious in bed, with a faint pulse initially; then the resident without pulse. The registered staff and PSWs performed lifesaving measures. The registered staff called 911 and initiated an internal code blue. After the paramedics arrived, the registered staff notified the physician, and the family was contacted and informed of the incident. Twenty-five minutes later, the resident passed away.

A review of staff training records for the home prevention of abuse and neglect of residents program indicated that not all direct care staff completed the training as required for 2013. (535)



**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

**Ministère 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

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

Jun 20, 2014



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*

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 : 003

Order Type /

Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 72. (2) The food production system must, at a minimum, provide for,

(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;

(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;

(c) standardized recipes and production sheets for all menus;

(d) preparation of all menu items according to the planned menu;

(e) menu substitutions that are comparable to the planned menu;

(f) communication to residents and staff of any menu substitutions; and

(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the food production system must, at a minimum, provide for, (c) standardized recipes for all menus.

This plan shall include but not limited to ensuring that standardized recipes are available for all menus and the preparation of all menu items according to the planned menu.

The plan shall be submitted to Diane.Brown@ontario.ca on or before May 16, 2014.

Grounds / Motifs :

1. The licensee failed to ensure that standardized recipes are available for all menus.

A review of recipes for week three of the menu cycle revealed 14 standardized recipes for homemade menu items. These recipes were not prepared and replaced with commercially prepared, outsourced products with no corresponding standardized recipe.

A review of recipes revealed recipes with ingredients crossed out, changed from fresh to frozen or added rendering the recipe not standardized. The western frittata recipe included olive oil which was changed for canola oil, fresh sliced green peppers replaced with frozen diced, fresh tomatoes replaced with diced canned, three cheese blend for cheddar cheese, diced ham removed and frozen california vegetables added.

An interview with the food service manager confirmed that changes to the menu from home made recipes to purchased, commercially prepared products were made, in part related to staffing resources and that recipes were not available for the commercially prepared products.

An interview with the home's registered dietitian revealed that she/he was not aware that homemade recipes were replaced with commercially prepared, outsourced products and that her/his approval of the menu was based on the original homemade recipes being followed.

A comparison of a homemade recipe with its substituted, outsourced product revealed that they were not nutritionally equivalent. The substituted product offered less energy and protein per serving than the homemade recipe.

(110)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 20, 2014



**Ministry of Health and
Long-Term Care**

**Ministère de la Santé et
des Soins de longue durée**

Order(s) of the Inspector

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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 or by fax upon:

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



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section 154 of the *Long-Term Care
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When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing 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
Performance Improvement and Compliance
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.



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RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11^e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.



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Pursuant to section 153 and/or
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la
conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of February, 2014

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : DIANE BROWN

Service Area Office /

Bureau régional de services : Toronto Service Area Office