Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 13, 2015	2015_299559_0013	T-1706-15	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

MACKENZIE PLACE
52 GEORGE STREET NEWMARKET ON L3Y 4V3

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

ANN HENDERSON (559), BARBARA PARISOTTO (558), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 2015.

During the course of the inspection, the inspector(s) spoke with the interim executive director, director of care (DOC), assistant director of care (ADOC), office manager, program manager, RAI coordinator, nutrition manager (NM), registered dietitian (RD), speech language pathologist (SLP), environmental services manager (ESM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), program aide, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **8 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 90. (2)	CO #001	2015_365194_0001	565

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that furnishings are maintained in a good state of repair.

On an identified date, the inspector observed the toilet seats and attached safety rails were loose and not secured to the toilets in resident bathrooms.

An interview with PSW #112 revealed he/she was not aware the toilet seats and safety rails were loose and did not provide firm support for residents.

An interview with the ESM confirmed the toilet seats and safety rails were not secure, had not been reported and should be fixed. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that furnishings are maintained in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an

assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A review of a resident #005's minimum data set (MDS) assessments indicated the resident had frequent bowel and bladder incontinence since admission and the resident had not received a continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence since admission.

Interviews with PSW #117 and RPN #105 identified the resident as being incontinent of bladder and bowel.

RPN #105 confirmed the resident did not receive a continence assessment using a clinically appropriate assessment instrument that is specifically designed to identify causal factors and types of incontinence. [s. 51. (2) (a)]

2. The resident #004's MDS assessments, revealed the resident's bladder continence status had changed from continent to frequently incontinent and record review identified the resident had not received a continence assessment using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Interviews with RPN #113 and RAI coordinator confirmed the resident's bladder continence status had changed to incontinent in the fall and further confirmed the resident did not receive a continence assessment that is specifically designed to identify causal factors and types of incontinence. [s. 51. (2) (a)]

3. A review of a resident #002's MDS assessments, revealed the resident's bowel continence status had changed from continent to usually continent.

A record review of the resident's plan of care and an interview with staff #109 revealed when the resident became incontinent a continence assessment was not conducted using an assessment instrument identifying causal factors, patterns, type of incontinence and potential to restore function.

An interview with the ADOC confirmed when the resident became incontinent a clinically appropriate assessment instrument specifically designed for incontinence was not

completed. [s. 51. (2) (a)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #3: 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. (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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other 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.

Record review of the meal service report, and a lunch observation conducted on the same date, revealed the resident #013 receives a modified diabetic diet with minced texture and honey thickened fluids.

Record review of the physician's order tab in PointClickCare (PCC) revised on an identified date, physician medication review signed on an identified date, and the written plan of care revealed the resident receives a modified diabetic diet with pureed texture

and honey thickened fluids.

A record review and interview with the NM revealed the resident's diet order was changed from a pureed texture to a minced texture.

Record review of a swallowing assessment conducted by a SLP and a nursing referral, revealed the resident was to continue with the current diet. The SLP's assessment indicated the recommended diet was puree, honey consistency.

An interview with the NM confirmed the nursing referral was reviewed and not the attached SLP assessment and made no changes to the meal service report at that time. The resident continued receiving a minced texture diet.

An interview with the RD revealed the SLP assessment was reviewed and updated the physician's order tab in PCC and the care plan to reflect the recommended puree diet.

An interview with the SLP confirmed the recommended diet assessment was in error and should have indicated minced texture. [s. 6. (4) (b)]

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

Record review of the recreation plan of care and staff interviews identified resident #009 as cognitively impaired and is to be provided with brief 1:1 visits to chat.

The program aide revealed the resident previously sat at the activation table during meals where staff would provide 1:1 conversations. When the resident required more assistance at meals, the resident was moved to a different table and at that time the 1:1 conversations during meal service stopped. Documentation identified the resident did not receive 1:1 visits over a three month period, and the program aide revealed the resident did not receive the brief 1:1 visits.

The program manager confirmed the resident had not received 1:1 visits as per the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the staff who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

A review of resident #004's plan of care indicated the resident was at risk for falls and requires one-person assistance for toileting and staff should not leave the resident unattended on the toilet.

An interview with PSW #112 revealed when he/she assists the resident to use the toilet, the resident would be left alone in the bathroom. The staff member confirmed he/she was not aware of the resident should not be left unattended on toilet. [s. 6. (8)]

4. The licensee has failed to ensure that the plan of care was revised when the resident's care needs change.

A review of the resident #004's plan of care identified the resident was at risk for falls and the resident fell on 5 occasions.

A review of the resident's post fall assessments on 2 identified dates, revealed a scheduled toileting plan was recommended for the resident.

A review of the resident's plan of care on an identified date, revealed the resident did not have a scheduled toileting plan.

RPN #113 and the RAI coordinator confirmed the plan of care was not revised when the scheduled toileting plan was implemented. [s. 6. (10) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure there are strategies developed and implemented to meet the needs of those residents with compromised communication in the home.

Record reviews and staff interviews identified resident #009 as hearing impaired and the resident uses an assistive device in the left ear. The assistive device is removed in the evening and returned to the resident after morning care. PSW #102 stated it was necessary to speak loudly into the resident's ear during morning care prior.

RPN #100 confirmed the resident with compromised communication would benefit from having the assistive device in place before morning care. [s. 43.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and O. Reg. 79/10, s. 48 (2).
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the continence program provides assessment and reassessment instruments.

An interview with the ADOC confirmed the home does not provide a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. A continence assessment instrument has been developed corporately and is not implemented in the home. [s. 48. (2) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

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

During an interview a Family Council member revealed the home does not always respond in writing in 10 days.

The Family Council meeting minutes for April 10, 2015, were reviewed. The Family Council had concerns about the labeling of clothing and inquired if there were other kinds of labels that would stay on if they were to use their own iron. The action of the home was to discuss with the ESM and management team and report back at the next meeting.

The Family Council assistant confirmed the concern was not responded to the Family Council in writing within 10 days. [s. 60. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term care home are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

The public inspection reports are available in a public information binder located by the main entrance. On June 5 and 8, 2015, the inspector observed the public inspection report 2015_365194_0001, issued on February 3, 2015, was not in the binder.

Interview with the interim executive director confirmed the home received the public inspection report and it was not posted in the public information binder located by the main entrance. [s. 79. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

An interview with a resident #007 revealed a watch went missing after bathing one evening approximately six months ago and the resident reported the missing watch to several staff. An interview with the resident's substitute decision-maker (SDM) confirmed the watch went missing and it was reported to the office manager.

The resident and SDM revealed a search did not locate the watch.
Staff interviews revealed a lack of awareness of the missing watch and the office manager indicated a client service response (CSR) form should be completed and given to the ED.
A record review of the 2014 and 2015 CSR forms failed to find a CSR form for the missing watch.

An interview with the ADOC confirmed a CSR form should have been completed for the resident's missing watch. [s. 101. (2)]

Issued on this 1st day of October, 2015

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

Original report signed by the inspector.