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

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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
Apr 10, 2015	2015_312503_0002	H-001869-15	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

NORTHRIDGE
496 POSTRIDGE DRIVE OAKVILLE ON L6H 7A2

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

LAURA BROWN-HUESKEN (503), LALEH NEWELL (147), VALERIE GOLDRUP (539)

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): January 19, 20, 21, 22, 23, 27, 28, 29 and 30, 2015

During the course of the inspection, the following critical incident and follow-up inspections were completed:
H-000365-14
H-000545-14
H-000744-14
H-000745-14
H-000851-14
H-000870-14
H-000879-14
H-001479-14
H-001725-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Food Service Manager, Registered Dietitian (RD), Environmental Services Manager, Acting Programs Manager, Resident and Family Council Presidents, Registered Staff, Personal Support Workers (PSW), Cooks, Dietary Aides, Housekeeping staff and Residents.

The Inspectors also toured the home, observed the provision of care and services, and reviewed documents including but not limited to: clinical health records, policies and procedures, employee records and meeting minutes.

The following Inspection Protocols were used during this inspection:

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2014_214146_0020	147
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_275536_0003	539

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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. The licensee failed to ensure that the home's policy "Height Measurement and Weight Management" was complied with.

The home's policy, "Height Measurement and Weight Management" LTC-G- 60 Revised June 2014, directed the staff to weigh residents monthly and to have the weight documented by the 7th day of each month. If a weight loss or gain is 2.0kg or greater from the preceding month, a re-weigh will be completed immediately.
An interview with the Director of Care and a review of clinical documentation found that the following identified residents did not have re-weighs completed when changes of greater than 2.0kg were recorded.
Resident # 200 weight loss of 3.7kg between December 2014 and January 2015.
Resident # 201 weight loss of 5.9kg between October 2014 and November 2014.
Resident # 202 weight loss of 2.9kg between September 2014 and October 2014. [s. 8. (1) (b)]

2. The licensee failed to ensure the home's policy "Management of Concerns/ Complaints/ Compliments" was complied with.

The home's policy, "Management of Concerns/Complaints/Compliments" LP-B-20, Revised October 2014, directed staff to initiate a "Client Service Response" (CSR) form when a verbal concern was raised to a staff member and the concern cannot be resolved immediately.

A review of clinical documentation revealed that Resident #101 reported that the resident's watch was missing on January 11, 2015 and a CSR form was not initiated. The resident's family inquired about the watch on January 20, 2105 and a CSR form was initiated at that time. Resident #105 reported that their Ipad was missing. Interviews with unit staff confirmed knowledge of the missing item; however, there was no CSR form located. Interview with the DOC confirmed that in both instances the CSR form had not been initiated when the concern was reported and the home's policy had not been complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

The quarterly review assessment for Resident #104, dated January 1, 2015, identified the resident was frequently incontinent of urine. The written plan of care did not include a bladder and bowel focus. The home's policy, "Continence Care", LTC-E-50, revised May, 2013 stated the "care plan will reflect the individualized needs of the Resident". The RAI Coordinator confirmed that the information should have been added when the plan of care was rewritten in 2014.

The quarterly review assessment for Resident #105, dated November 3, 2014, identified the resident was frequently incontinent of urine. The written plan of care did not include a bladder and bowel focus. The home's policy, "Continence Care", LTC-E-50, revised May,

2013 stated the "care plan will reflect the individualized needs of the Resident". The Resident Assessment Instrument (RAI) Coordinator confirmed that the information should have been added when the written plan of care was rewritten in 2014. [s. 6. (1) (a)]

2. Interviews with PSWs, Registered Nursing staff, and a review of clinical documentation revealed that Resident #110 had bladder incontinence and required the use of continence care products. The resident's written plan of care did not include reference to the resident's bladder incontinence or the use of continence care products. The DOC confirmed that the resident's written plan of care did not include the planned care for the resident related to continence. [s. 6. (1) (a)]

3. The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

The plan of care for Resident #101 indicated that the resident was independent with meals. Interviews with PSWs and review of clinical documentation revealed that the resident required set-up assistance, supervision and cueing. The RD confirmed that care set out in the plan of care was not based on the needs of the resident. [s. 6. (2)]

4. 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 of care.

The plan of care for Resident #110 directed staff to provide the resident with a 206 nutritional cookie at afternoon snack related to the resident's low body weight. A review of the home area's snack list, clinical documentation and staff interviews revealed that the resident was not receiving the 206 nutritional cookie. The RD confirmed that the 206 nutritional cookie was not being provided as specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that the care set out in the plan of care is provided to the resident as specified in the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. Not all of the following were satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD considered, the use of the PASD was reasonable given the resident's condition, consent had been obtained and the device was approved.

A. Resident #108 used one three quarter rails when in bed as a PASD to assist with bed mobility. Review of the resident's health records and interview with the DOC indicated that there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the DOC and Registered Practical Nurse (RPN) also confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use.

B. Resident #109 used one quarter rails when in bed as a PASD to assist with bed mobility. Review of the resident's health records and interview with the DOC indicated that there was no documented evidence to support that an assessment identifying other alternatives were tried prior to the use of the bed rails. Interview with the DOC and Registered Practical Nurse (RPN) also confirmed that an approval of the PASD by an appropriate person, as defined in the legislation, was not obtained, nor was there a consent documented from the resident or their substitute decision maker for the use. [s. 33. (4)]

2. Resident #104 used two half rails when in bed as a PASD to assist with bed mobility. The written plan of care stated that the resident was to have "both siderails up while in bed for repositioning". The Registered Staff and DOC could not locate health records that included an assessment identifying other alternatives were tried prior to the use of the bed rails, nor a record that included the approval of the PASD by an appropriate person as defined in the legislation and consent documentation. [s. 33. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all of the following are satisfied prior to including the use of a PASD to assist in routine activities of daily living: alternatives to the use of the PASD considered, the use of the PASD is reasonable given the resident's condition, consent has been obtained and the device is approved, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

A review of the home's internal investigation notes indicated that on an identified date while resident #401 was being toileted by one PSW, the resident exhibited responsive behaviours. The PSW was unable to manage the resident's responsive behaviour and called for the Registered staff for assistance. When the Registered Staff came on the scene, the PSW was forcefully holding both of the resident's wrists in an attempt to minimize any injuries to the resident and herself. The Registered Staff was able to

deescalate the situation and both the resident and the PSW were agitated and upset. A head to toe assessment was completed by the Registered Staff and two small bruises were observed on both of the resident's wrists where the PSW was holding.
Interview with the DOC and review of the resident's clinical records indicated that due to resident's ongoing responsive behaviours, two staff were to provide ongoing care to the resident. The resident's plan of care related to responsive behaviours was modified and developed to ensure that two staff should be present if behaviours are anticipated to minimize any risks to the resident and the staff. The resident had a history of responsive behaviours towards the staff during care and was being followed by the Behavioural Supports Ontario (BSO) as well as Halton Geriatric Mental Health Outreach Program. However, review of the internal investigation notes indicated that the PSW did not implement these strategies in response to the resident's responsive behaviours and toileted the resident without the presence of a second PSW. [s. 53. (4) (b)]

2. The licensee has failed to ensure that actions were taken to meet the needs of the resident with responsive behaviours which included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

On an identified date resident #302 was observed to grab and twist the arm of resident #301 in an identified dining area during the breakfast meal. A review of the quarterly review assessment for resident #302 dated November 28, 2014 under their mood and behaviour identified a deteriorated change in behaviour symptoms.

A review of the progress notes identified that during an identified two month time period there were thirty-three other documented episodes of behaviours. None of these behaviours were documented under the title of behaviour in the electronic record.

There was no electronic or written documentation that indicated that the resident had been assessed as specified in the home's "Dementia Care" policy, revised August, 2012 and the home's Care Pathway for Responsive Behaviours using a comprehensive assessment such as a "P.I.E.C.E.S. assessment" outlined in the home's policy. This was confirmed with a member of the registered staff.

There was no electronic or written documentation indicating that the resident was started on behavioural monitoring in accordance with the home's "Dementia Care" policy, revised August, 2012 and the home's Care Pathway for Responsive Behaviours such as a "Dementia Observation System". This was confirmed with a member of the registered staff.

Furthermore, there was no electronic or written documentation that indicated that resident interventions were initiated as per the home's Care Pathway for Responsive Behaviours and evaluated in "2 weeks or sooner as needed" as the pathway guided. Blood work was not initiated until just prior to the last incident and not obtained before the last incident occurred. This was confirmed with a member of the Registered Staff. [s. 53. (4) (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, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible and to ensure that actions are taken to meet the needs of the resident with responsive behaviours which included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that nutrition care and hydration program included a system for measuring resident's heights on admission and annually thereafter.

An interview with the DOC and a review of clinical documentation found that the following identified residents did not have heights completed on an annual basis.
Resident #200 was admitted in August 2012 and had one height completed in September 2012.
Resident #201 was admitted in November 2011 and had heights completed in November 2011 and February 2012.
Resident #202 was admitted in August 2011 and had one height completed in February 2012. [s. 68. (2) (e) (ii)]

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 nutrition care and hydration program includes a system for measuring resident's heights on admission and annually thereafter, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness.

On January 19, 2015, the long-term care homes inspector observed the lunch meal service on the Sumner home area and a visitor was observed to enter the servery area twice without wearing a hair net. An interview with the Food Services Manager confirmed that hairnets are to be worn in the servery to prevent contamination of the food being served. [s. 72. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids are prepared, stored, and served using methods which prevent adulteration, contamination and food borne-illness, to be implemented voluntarily.

WN #7: 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: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

On January 19, 2015, during the lunch meal service on the Sumner home area the steam table was found to be non-functional by the long-term care homes inspector as reported by nursing and dietary staff. At the conclusion of meal service to the residents in the dining room trays were prepared for residents who were consuming meals in their rooms. The main course of turkey and cranberry pie, puree texture, was reported to be 39 degrees Celsius. Two trays were delivered to residents without the food being reheated. One tray was returned by the serving staff to be reheated as it was reported to be too cold. The home's Meal Service Temperature Standard, FSO-D-30 dated November 2011, directs staff to reheat food with a temperature below 60 degrees Celsius. Interview with the Food Services Manager confirmed that the food should have been reheated to a palatable temperature prior to service to the residents. [s. 73. (1) 6.]

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 food and fluids are served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #8: 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 failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The room of Resident #110 was observed on January 22, 23, 27, and 28, 2015 and the room was noted to have tissue paper on the floor near the head of the bed and under the bed as well as a plastic cup under the bed. An interview with the Environmental Services Manager confirmed that the resident's room was not clean. [s. 15. (2) (a)]

WN #9: 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 home's resident-staff communication and response system that is on at all times.

On January 20, 2015, when the cord affixed to the resident-staff communication and response system in the bathroom of room 2115 was pulled by the long-term care homes inspector the mechanical box fell out of the wall. Pulling the cord did not activate the communication system. The unit nurse confirmed that communication system was not functional and indicated that maintenance would be notified to have it fixed. [s. 17. (1) (b)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that home's written policy to promote zero tolerance of abuse and neglect of residents is complied with.

Review of the home's internal investigation notes and interviews with an identified staff member and the DOC revealed that on December 12, 2014, a member of the home's staff reported an allegation of verbal abuse towards a resident from an attending PSW. The staff member reported that the incident occurred approximately one month earlier. A review of employee records revealed that the reporting staff member had received training on the home's policy "Resident Non-Abuse -Ontario ", LP-C-20-ON, revised September 2014. The policy directed staff who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident to report the suspicion immediately to the Executive Director or the most senior supervisor on shift at the time. Interviews with reporting staff member and the DOC confirmed that the suspected verbal abuse was not reported until approximately one month after the incident occurred and home's policy, Resident Non-Abuse -Ontario, had not been complied with. [s. 20. (1)]

WN #11: 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 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 appropriated assessment instrument that is specifically designed for assessment of incontinence.

Interviews with staff and a review of clinical documentation revealed that Resident #110 had bladder incontinence and required the use of continence care products. Review of the resident's health records and interview with the DOC indicated that there is no documented evidence to support that an assessment identifying the causal factors, patterns, type of incontinence and potential to restore function was completed for the resident. [s. 51. (2) (a)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Resident #108 requires the use of a wheelchair for mobility. Both sides of the lower frame of the wheelchair were noted to be have visible debris on January 22, 23, 27 and 28, 2015. Interview with the DOC and review of documentation revealed that the resident's wheelchair was to be cleaned on Tuesday nights and as needed. The DOC confirmed that the resident's wheelchair was not cleaned as per the schedule. [s. 87. (2) (b)]

Issued on this 17th day of April, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	LAURA BROWN-HUESKEN (503), LALEH NEWELL (147), VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2015_312503_0002
Log No. / Registre no:	H-001869-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 10, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	NORTHRIDGE 496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Harris

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 # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0008, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home's policy, "Height Measurement and Weight Management" LTC-G- 60 Revised June 2014, is complied with. This plan should include, but not be limited to:
A) Processes and schedules for monitoring staff's compliance with the policy.
The plan is to be submitted to Laura.Brown-Huesken@ontario.ca by May 1, 2015.

Grounds / Motifs :

1. This section was previously issued as a VPC in October 2013 and a CO in April 2014.

The licensee failed to ensure that the home's policy "Height Measurement and Weight Management" was complied with.

The home's policy, "Height Measurement and Weight Management" LTC-G- 60 Revised June 2014, directed the staff to weigh residents monthly and to have the weight documented by the 7th day of each month. If a weight loss or gain is 2.0kg or greater from the preceding month, a re-weigh will be completed immediately.
An interview with the Director of Care and a review of clinical documentation found that the following identified residents did not have re-weighs completed when changes of greater than 2.0kg were recorded.
Resident # 200 weight loss of 3.7kg between December 2014 and January 2015.
Resident # 201 weight loss of 5.9kg between October 2014 and November 2014.
Resident # 202 weight loss of 2.9kg between September 2014 and October 2014. (503)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 20, 2015

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

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.

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, 11e 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.

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 10th day of April, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Laura Brown-Huesken

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