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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2018;	2017_633577_0015 (A1)	009006-17, 010551-17, 013736-17	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Roseview Manor
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This order has been closed due to the fact that this licensee is no longer responsible for the management of this long-term care home as March 01, 2018. The new licensee will be responsible to ensure compliance with the Long-Term Care Homes Act, 2007, as per the conditions of their licence.

Issued on this 28 day of February 2018 (A1)

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

Original report signed by the inspector.

Ontario

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Roseview Manor
99 Shuniah Street THUNDER BAY ON P7A 2Z2

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 2, 3, 4, 16, 2017.

This Complaint inspection was conducted concurrently with Critical Incident System inspection #2017_633577_0016.

The following intakes were inspected:

-one log related to care concerns and a resident fall

-one log related to a resident fall

-one log related to care concerns and weight loss

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Assistant Director of Care (ADOC), Food Services Manager (FSM), Registered Dietitian (RD), Recreation Manager, Registered Practical Nurses (RPNs), Recreation Therapists, Personal Support Workers (PSWs), and Family Members.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Hospitalization and Change in Condition

Nutrition and Hydration

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

2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report and a complaint was received by the Director in May 2017, which indicated that resident #002 had a fall which resulted in an injury.

Inspector #577 conducted a record review of resident #002's care plan interventions in place at the time of fall which indicated that staff were to follow specific instructions related to the resident's wheelchair.

During an interview with the Assistant Director of Care (ADOC) and Executive Director (ED) on August 4, 2017, they confirmed that PSW #106 did not follow the plan of care which resulted in resident #002 falling out of their wheelchair. [s. 6. (7)]

2. A complaint was received by the Director in June 2017, which alleged that resident #004 had weight loss and was not being assisted by staff during the complainant's absence from the home. The report further alleged that they had observed the resident still in bed without being given a meal on five different occasions.

a) During an interview in August 2017, the complainant was on the resident's home unit and reported to the Inspector that they arrived late that morning and observed the resident was still in bed. They reported that they approached two staff members on the unit and inquired whether the resident had breakfast and they allegedly reported that they did not know. They further reported that they spoke with RPN #102 who reported that the resident did not have breakfast.

During an interview on that same day in August 2017, at 1100hrs, PSW #103

reported that resident #004 did not get up that morning until a specific time. PSW #103 reported to the Inspector that the resident didn't have breakfast and they had not gotten the resident up because they were busy. The PSW confirmed with the Inspector that resident #004 was supposed to be up in the morning.

Inspector #577 conducted a record review of resident #004's care plan which indicated that staff were to ensure that the resident was up for all meals.

During an interview with the ADOC on August 3, 2017, they confirmed with Inspector #577 that it was expected that all residents are up for the breakfast meal service.

b) Inspector #577 conducted a record review of resident #004's weight history and found a significant weight change over one specific month in 2017.

During a record review of the Registered Dietitian (RD) orders in August 2017, Inspector #577 found an order for registered staff to give one bottle of a nutritional supplement for a specific reason, which was ordered in December 2016.

A record review of resident #004's care plan instructed registered staff to review the Electronic Medication Administration Record (EMAR) for nutritional supplements and to document if the as needed (prn) supplement was administered.

Inspector #577 conducted a record review of electronic meal intakes on August 4, 2017, for two months and found the following:
-22 times a supplement should have been given for one month in 2017
-20 times a supplement should have been given for another month in 2017

Inspector #577 conducted a record review of resident #004's EMAR's which indicated a nutritional supplement to be used for a specific reason. A review of those records for two specific months in 2017 indicated that the nutritional supplement was not given at all for the specific reason.

A record review of a Nutritional Assessment dated December 2016, documented by the RD indicated the intervention for staff to provide a nutritional supplement prn at specific times and to document when the prn order was used.

Inspector #577 conducted a record review of a quarterly Nutritional Assessment

documented by the Food Services Manager (FSM), dated May 2017. The assessment did not include the intervention of a nutritional supplement ordered to be administered at specific times.

On August 4, 2017, Inspector #577 spoke with RPN #102 who confirmed that the nutritional supplement prn was not given for two specific months in 2017.

During an interview with the RD on August 16, 2017, they reported that they did not review the EMAR record to determine if the nutritional supplement was ever given. They further confirmed that nursing staff did not send them a referral and they review all of the resident's weights before the seventh of the month and determines any loss or gain.

During an interview on August 4, 2017, with the ADOC and ED, they confirmed that for two specific months in 2017, registered staff did not administer the prn nutritional supplement that was ordered when it was required. [s. 6. (7)]

Additional Required Actions:

(A1)The following order(s) have been rescinded:CO# 001

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of an incident under subsection (1), (3) or (3.1), within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: Actions taken in response to the incident, including the outcome or current status of the individual or individuals who were involved in the incident.

A Critical Incident System (CIS) report was received by the Director in August 2016, related to resident #001's fall with a significant injury.

A complaint was received by the Director in May 2017, concerning care issues and a fall with injuries of resident #001.

Inspector #577 conducted a record review of the most current amended CIS report, which indicated that resident #001 remained in the hospital and suffered a significant injury.

During an interview with the Assistant Director of Care (ADOC) and Executive Director (ED) on August 2, 2017, they both confirmed that they did not amend the CIS report to inform the Director of the outcome of the incident. [s. 107. (4) 3.]

Issued on this 28 day of February 2018 (A1)

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543) - (A1)

Inspection No. / No de l'inspection : 2017_633577_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009006-17, 010551-17, 013736-17 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Feb 28, 2018;(A1)

Licensee / Titulaire de permis : Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

LTC Home / Foyer de SLD : Roseview Manor
99 Shuniah Street, THUNDER BAY, ON, P7A-2Z2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Joanne Lent

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

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

(A1)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

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

Issued on this 28 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TIFFANY BOUCHER - (A1)

Ontario

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Service Area Office / Bureau régional de services : Sudbury