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

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

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) :	LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2013_104196_0005
Log No. / Registre no:	S-001253-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 11, Jul 9, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
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

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to residents #002 and #003 as specified in the plan.

This order is linked to previous CO #01 from inspection 2012_104196_0025.

Grounds / Motifs :

1. On March 20, 2013, the inspector reviewed the current care plan for resident #003 and noted that under the focus of "Risk for falls" there was an intervention of "Use falling star logo in Resident room/wheelchair to identify at risk resident". The inspector observed resident #003's room to determine if there was a "falling star logo" above the resident bed or on the name plate outside the entrance to the room and none were found. According to staff member #101, "never heard of the falling star logo".

The licensee failed to ensure that the care set out in the plan of care is provided to resident #002 as specified in the plan. (196)

2. The inspector observed on March 20, 2013 at 1445hrs, resident #002 lying in bed with 3/4 bilateral side rails elevated and a floor mat beside the bed. The bed alarm was not attached to the resident. The inspector conducted an interview with staff member #103 at the time of the resident observations, and they reported that resident #002 was a fall risk and should have had the alarm attached. Staff member #103 then proceeded to apply the tabs bed alarm to the resident.
The health care records for resident #002 were reviewed by the inspector. The kardex noted that a bed alarm is to be applied to the resident while in bed for safety and the care plan included an intervention of "make sure bed alarm is on whenever in bed" under the focus of "risk for falls".

The licensee failed to ensure that the care set out in the plan of care is provided to resident #003 as specified in the plan. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2013

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 9th day of July, 2013

Signature of Inspector / Signature de l'inspecteur : Lauren Tenhunen #196.

Name of Inspector / Nom de l'inspecteur : Lauren Tenhunen

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

Ontario

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

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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

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

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 20, 21, 22 2013

Ministry of Health and Long-Term Care (MOHLTC) Log #

During the course of the inspection, the inspector(s) spoke with Administrator, the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents

During the course of the inspection, the inspector(s) observed the provision of care and services to residents, reviewed the health care records of several residents

Ad-hoc notes were used during this inspection.

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 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. (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. During the course of inspection, the inspector observed resident #003 lying in bed with bilateral 3/4 bed rails elevated, bed in its lowest position and a floor mat on the floor beside the bed. A bed alarm was noted at the bedside but was not attached to the resident. According to staff member #103, a bed alarm is to be used on resident #003 when in bed and staff member #103 proceeded to apply the alarm to the resident upon determining it had not been attached. The health care record for resident #003 was reviewed by the inspector. The plan of care did not include the use of a bed alarm.

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. During the inspection, an interview was conducted by the inspector with staff member #104 regarding resident #007's continence care requirements. It was reported that this resident wears a pull up brief during the daytime, will ask to go to the washroom and is also incontinent at times. According to staff member #105, resident #007 "wears a pull up cause it isn't bulky, where a day pad is uncomfortable for (them). Family want (them) to wear a pull up brief, occasionally dribbles. Wears a full brief at night as (they are) incontinent".
The Point of Care documentation for the day shift on two particular days, notes the use of incontinent products yet the kardex as found on the Point of Care system, under the category of "Toileting and Continence" does not include the use of any briefs or incontinence products. On March 22, 2013, the inspector reviewed the current care plan for resident #007. Under the focus of "Maintain Bladder and Bowel Continence" it identifies the resident as being "frequently incontinent" with interventions of "uses continent products: Nights: purple brief and Incontinent program: toilet ac, pc meals and hs". In this same care plan, under the focus of "Toileting" the interventions include "Brief to be used only on night shift and changed during change rounds prn".

The licensee failed to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The inspector observed, during the course of inspection, resident #002 lying in bed with 3/4 bilateral side rails elevated and a floor mat beside the bed. The bed alarm

was not attached to the resident. The inspector conducted an interview with staff member #103 at the time of the resident observations, and they reported that resident #002 was a fall risk and should have had the alarm attached. Staff member #103 then proceeded to apply the tabs bed alarm to the resident.
The health care records for resident #002 were reviewed by the inspector. The kardex noted that a bed alarm is to be applied to the resident while in bed for safety and the care plan included an intervention of "make sure bed alarm is on whenever in bed" under the focus of "risk for falls".

The licensee failed to ensure that the care set out in the plan of care is provided to resident #002 as specified in the plan. [s. 6. (7)]

4. On March 20, 2013, the inspector reviewed the current care plan for resident #003 and noted that under the focus of "Risk for falls" there was an intervention of "Use falling star logo in Resident room/wheelchair to identify at risk resident". The inspector observed resident #003's room to determine if there was a "falling star logo" above the resident bed or on the name plate outside the entrance to the room and none were found. According to staff member #101, "never heard of the falling star logo".

The licensee failed to ensure that the care set out in the plan of care is provided to resident #003 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be 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 that ensures the written plan of care for resident #003 and #007 sets out clear directions to staff and others who provide direct care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Resident #003 was observed on March 20, 2013 with a front closing seat belt in place while in a wheelchair. The inspector conducted an interview with staff member #101 and it was reported that the resident uses a front closing seat belt when in the wheelchair and it is considered a restraint as the resident can't release it. In addition, the current care plan included the focus of "Restrained for safety to prevent falls using Wheelchair with front closing seat belt".
The health care record for resident #003 was reviewed by staff member #101 and the inspector and determined there was not a written order for the use of a restraint from either a physician or from the nurse practitioner.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

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 that ensures that staff only apply the physical device to resident #003, that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. On March 20, 2013, the inspector conducted the initial walk through of the home. On one particular unit, a resident care cart was observed in a resident room, unlocked, containing prescription topical medications for residents, and no staff member was within sight. The resident care cart contained prescription topical medications for three separate residents. The inspector conducted an interview with staff member #100 and they reported that there was no lock on the resident care cart as it is broken.

2. Inspector observed a container of prescription topical medication, labelled with resident #001's name, on their bedside table. According to staff member #101, the resident is unable to apply the cream on their own but likes to have it at the bedside so they can see it. In addition, there was no physician's order to leave this topical medication at the resident's bedside.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. [s. 129. (1) (a) (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 that ensures that drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

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:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

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. 6. (7)	CO #001	2012_104196_0025	196

Disregard table above. LTCHA, 2007, c.8, s.6(7) is not a complied order. J.T. July 9/13

Issued on this 9th day of July, 2013

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

Lauren Lenhuren #196.