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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2014	2014_251512_0006	T-091-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

SHERWOOD COURT LONG TERM CARE CENTRE
300 Ravineview Drive, Maple, ON, L6A-3P8

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

TILDA HUI (512), MATTHEW CHIU (565), NITAL SHETH (500), SLAVICA VUCKO (210), STELLA NG (507)

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): May 14, 15, 16, 20, 22, 23, 26, 27, and 28, 2014.

Additional inspections related to the following LOG#'s were also completed during this inspection:
1) T-302-13, complaint
2) T-392-13, critical incident
3) T-636-13, critical incident
4) T-271-14, critical incident
5) T-407-14, critical incident
6) T-594-14, critical incident
7) T-731-13, follow-up order

During the course of the inspection, the inspector(s) spoke with the acting executive director(ED), interim acting executive director, director of care(DOC), associate director of care(ADOC), resident service coordinator & staff educator, food service manager(FSM), environmental service manager, regional manager of clinical services, physiotherapist(PT), registered dietitian(RD), registered nurse(RN), registered practical nurse(RPN), personal support worker(PSW), housekeeping aide, cook, residents, family members and substitute decision makers.

During the course of the inspection, the inspector(s) conducted observation in home and resident's areas, observation in care delivery processes, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all direct care staff received annual training in skin and wound care.

Interviews with registered nursing staff and ADOC revealed that the home did not provide skin and wound care training to all direct care staff in 2013.

A review of the training report statistics provided by the home indicated that in 2013, 26.3% of staff had attended skin and wound training. [s. 221. (1) 2.]

2. The licensee failed to ensure that all direct care staff received annual training in continence and bowel management.

A review of training record for 2013, revealed that 29.8% of the direct care staff received training in continence and bowel management.

Phone interview with DOC by inspector #512 indicated that 61% of staff had attended the continence and bowel management training in 2013. The DOC stated that the initial record did not capture some of the staff who had attended the training. The DOC faxed the revised training reporting statistics and attendance lists to confirm the change. [s. 221. (1) 3.]

3. The licensee failed to ensure that direct care staff received annual training in falls prevention and management. An inspection has been conducted on October 15, 2013, and a compliance order has been issued for s.221(2) on December 4, 2013, with a compliance date for February 28, 2014.

A review of the home's record confirmed that 37% and 45% of direct care staff received training in falls prevention and management in 2012 and 2013 respectively. The licensee was ordered to prepare, submit and implement a plan to ensure that all direct care staff receive training in falls prevention and management annually, or as per their individual training needs based on an assessment conducted by the licensee.

The licensee submitted the plan to the Ministry on December 20, 2013, which includes the following plan of actions:

1. Staff who were identified as not having received falls prevention and management training in 2013 will receive falls prevention and management training by February 28, 2014.

Record review revealed and staff interview confirmed that 34 direct care staff identified did not receive falls prevention and management training in 2013. Five direct care staff (16%) did not receive the training as required by the home's submitted plan by February 2014.

2. Short-term plan of actions include conducting training needs assessment with staff annually and establish a falls committee.

Record review revealed and staff interview confirmed that the training needs assessment with staff had not been conducted, and the falls committee had not been established as of May 23, 2014. [s. 221. (2) 1.]

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 in ensuring that all direct care staff are provided with annual training in skin and wound care, and continence and bowel management, to be implemented voluntarily.

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

Findings/Faits saillants :

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

On May 22, 2014, the inspector observed two wire coat hangers hanging on the grab bar in the hallway directly opposite room #2207. Interview with an identified PSW confirmed that the hangers should not be there because it is unsafe; residents could take them and hurt themselves or other residents. The identified PSW took the wire coat hangers away.

On May 23, 2014, the inspector observed that the small wooden set of swinging door to the servery on the first floor was closed, but not latched. There were six residents sitting in the dining room, and one resident was walking into the dining room at that time. A PSW was sitting in a corner of the dinning room. Interview with the identified PSW confirmed that the door should be latched at all times and he/she then put the latch on. [s. 5.]

2. On May 16, 2014, inspector #500 observed the vent cover at the ceiling of the entrance to the spa room in unit Via Roma was loose; one side of the vent cover came off and was not screwed in. On May 23, 2014, inspector #507 observed the same vent cover remained loose and not screwed in. Interview with the environmental service manager confirmed that this was unsafe because the vent cover can come off and hit a resident. [s. 5.]

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 in ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #3: 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 on skin and wound care put in place is complied with.

The home's policy titled Revera Skin & Wound Care Program, revised date March 2014, was reviewed. The policy stated that "All residents exhibiting altered skin integrity will be assessed by the nurse on initial discovery and reassessed with every dressing change but minimum weekly".

Same policy also stated that "The nurse/wound care coordinator will complete a referral to Nutritional Care/Registered Dietitian (RD) for all residents exhibiting altered skin integrity. The dietitian will complete an assessment, document, communicate to the interdisciplinary team any nutritional interventions to be implemented, and update the resident's care plan as necessary".

Clinical records reviewed indicated that resident #595's stage 2 pressure ulcer was identified on November 16, 2013. There were no reassessment recorded after November 16 to December 3, 2013, and from December 12, 2013, to January 10, 2014. The RN noted on February 15, 2014's assessment that the ulcer had progressed to stage 3.

Clinical records reviewed indicated that the referral made to RD was delayed on November 16, 2013, and the nutritional and hydration assessment was not conducted until December 3, 2013. [s. 8. (1) (a),s. 8. (1) (b)]

2. Record review revealed that resident #562 had a history of a healed pressure ulcer in December 2013. The ulcer reopened on January 29, 2014, as indicated by report from PSW to registered nursing staff. A referral to RD was made on February 4, 2014, and new interventions related to nutrition and hydration were initiated on February 11,

2014, as indicated on the plan of care.

Clinical records reviewed indicated that the referral made to RD was not made in a timely manner and new nutritional interventions were delayed as a result.

Interview with RD and registered nursing staff confirmed that it was the home's practice to initiate referral to RD when a stage 2 pressure ulcer has been identified, and not at identification of any altered skin integrity as stated in the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the policy, protocol, or procedure for international normalized ratio (INR) is complied with.

A review of the home's INR protocol signed by the physician on August 7, 2013, indicated that the Warfarin order be continued if resident #005's INR was 1.8 to 3.2, the physician to be called for direction if INR is less than 1.8 or greater than 3.2.

Interview with the regional manager of clinical services who was acting DOC on July 2013, and review of the clinical record for the resident indicated on July 18, 2013, a laboratory result was received for the resident's INR at 1.0. The laboratory result was placed in the physician's communication book for review at the next physician's visit. The physician was not called for direction. The resident was sent to hospital on July 20, 2013, and passed away on July 21, 2013, from unrelated causes . [s. 8. (1) (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 the home's policy, protocol, or procedure on skin and wound care, and for international normalized ratio (INR) are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents are provided with food and fluids that are safe, and adequate in quantity.

Observation conducted on May 24, 2014, at 12:30 p.m., on an identified unit's dining room revealed that an identified resident was served regular textured pork tortiere and herbed spinach.

A review of the resident's plans of care revealed that the resident should be provided with minced texture.

Interviews with FSM confirmed that resident should be provided minced textured food by the dietary staff instead of the regular textured food.

Observation conducted on May 14, 2014, at 12:30 p.m., on the identified unit's dining room revealed that dietary staff did not use standardized scoop size when serving food. Scoops size #10 were used instead of #08 for serving ratatouille, minced ratatouille case, minced salad green, pureed ratatouille case and pureed salad green.

Interview with dietary staff and director of support services confirmed appropriated scoop sizes should be used for all food items as per the menus, as using different scoop sizes may alter the quantity and nutrient value of the foods. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are provided with food and fluids that are safe, and adequate in quantity, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The Licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Observation made on May 20, 2014, in an identified resident's room, revealed that two half side rails were in the up position on both sides of the beds with resident in bed.

Observation made on May 20, 2014, and May 22, 2014, in two other identified residents' rooms, revealed that two quarter bed side rails were in the up position on both sides of the bed for both residents.

Reviews of the written plans of care confirmed that the bed side rails were used to facilitate the residents' bed mobility. No assessments on the use of the bed side rails was noted in the residents' plan of care.

Record review and interview with nursing staff and physiotherapist confirmed that the residents were not assessed for the use of the bed side rails. [s. 15. (1) (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 where bed rails are used, residents are assessed and his or her bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the residents, to be implemented voluntarily.

WN #6: 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 is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.

On May 15, 2014, inspector #500 observed the call bells in two identified rooms were not functioning.

On May 22, 2014, inspector #507 observed the call bells described above remained non-functioning.

Interview with a registered nursing staff confirmed that the above call bells were not functioning and PSWs were required to check all call bells at the beginning of his/her shifts. The registered nursing staff stated that he/she was not aware of the non-functioning call bells prior to the interview.

Interview with the ADOC confirmed that the above call bells were fixed by maintenance staff after receiving requests from the registered nursing staff.

On May 23, 2014, inspector #507 observed the call bells in the above mentioned rooms were functioning. [s. 17. (1) (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 the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when/if a person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director.

Record review revealed and staff interview confirmed that the licensee received a complaint from a resident that a staff member was rough when providing care to him/her on January 15, 2014. The home conducted an internal investigation and did not report the suspicion and the information upon which it was based to the Director until January 17, 2014, two days after the alleged abuse was reported to the home. [s. 24. (1)]

2. Record review and staff interview confirmed that the identified resident was visited by a family member on February 14, 2014. The resident had bladder and bowel incontinence, and had been using an incontinent product, and required assistance with continence care.

Interview with the ADOC confirmed that on February 21, 2014, the resident's daughter reported to the home that the resident's incontinent brief was not changed for the entire day shift on February 14, 2014. The ADOC interviewed the identified staff on February 21, 2014, on the suspicion of neglect of the resident by the staff. The home did not report this incident to the Director until February 24, 2014. [s. 24. (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 to immediately report when a person who had reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately report suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training on the duty under section 24 to make mandatory reports prior to performing their responsibilities.

Review of the home's training material for staff orientation and on-going education revealed that the above mentioned requirement was not included.

Interview with the DOC confirmed that the training material did not include the requirement for staff to report abuse and neglect to the Director of the Ministry of Health and Long-Term Care. [s. 76. (2) 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 staff receive training on the duty under section 24 to make mandatory reports prior to performing their responsibilities., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interview with the regional manager of clinical services who was acting DOC in 2003 confirmed that the infection prevention and control program evaluation was not conducted for 2012 and 2013 due to turn over of management staff including DOC who was the lead for the program. [s. 229. (2) (d)]

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

On May 27, 2014, inspector #507 observed an identified registered nursing staff did not perform hand hygiene prior to and post giving medication to an identified resident. The registered nursing staff confirmed that he/she should have perform hand hygiene prior to giving medication. [s. 229. (4)]

3. Observation made on May 14, 2014, at 1 p.m. by inspector #512 revealed an unlabeled tooth brush and a hair brush on the counter of a shared bathroom in an identified resident's room.

Observation made on May 15, 2014, at 11:23 a.m. by inspector #210 revealed unlabeled tooth brushes in the shared bathrooms in another two identified residents' rooms.

Interview with PSWs confirmed that the personal care items should have been labeled with the individual resident’s name. [s. 229. (4)]

4. The licensee failed to ensure that there is access to point-of-care hand hygiene agents.

Observation made on May 28, 2014, at 10 a.m. revealed that on an identified unit, there was no hand hygiene agents at point-of-care in an identified shared resident's room. There was a sink in the adjacent washroom, and a hand sanitizer dispenser in the hallway.

Interviews with ADOC and DOC confirmed that hand sanitizer dispensers were not installed in single rooms and in some of the shared rooms. [s. 229. (9)]

5. The licensee failed to ensure each resident admitted to the home was screened for tuberculosis (TB) within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results

of this screening are available to the licensee.

Record review revealed that there were no records of TB screening conducted for two identified residents on admission, and for the third identified resident, step one Mantoux test was given on the day of admission but the result was not documented.

Interview with registered nursing staff and DOC confirmed that TB screening should have been conducted for the residents. [s. 229. (10) 1.]

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

Record review revealed that immunizations against pneumoccocus, tetanus and diphtheria were not offer to four identified residents on admission.

Interviews with registered nursing staff and DOC confirmed that the home did not routinely offer the above mentioned immunizations to residents. [s. 229. (10) 3.]

7. The licensee failed to ensure that staff are screened for tuberculosis in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Record review revealed that there were no record of TB screening for two identified staff hired in the past two years.

Interview with DOC confirmed that records of TB screening on these two staff were not available. [s. 229. (10) 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 the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; that staff participate in the implementation of the infection prevention and control program; that there is access to point-of-care hand hygiene agents; that residents and staff are screened for TB; and that immunizations against pneumoccocus, tetanus and diphtheria are offered to residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (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 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.

Record review of progress notes for an identified resident revealed that the resident requested whenever his/her door was open during the evening, that staff should come

in his/her room to offer a back wash with a warm towel.

A review of the written plan of care and interview with the registered nursing staff confirmed that this intervention was not included in the plan of care, and that the written plan of care did not set out clear directions to staff who provide direct care to the resident. [s. 6. (1) (c)]

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

Review of skin and wound assessments revealed conflicting information on the description of ulcer stages. A stage 3 pressure ulcer of an identified resident was described as stage 2 on two separate assessments conducted on the same day by two different registered nursing staff.

Interview with ADOC and registered nursing staff confirmed that there had been inconsistencies among registered nursing staff and nursing management in describing ulcer stages. ADOC stated that it could be directly related to the lack of education provided to staff. [s. 6. (4) (a)]

3. 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.

Interview with an identified resident revealed that on an identified date in 2014, resident had to wait for an hour to get assistance for dressing as PSW assigned to provide care did not come in.

Interview with registered nursing staff and DOC confirmed that the assigned PSW for the resident had to attend a meeting on that morning. A replacement PSW was later sent to assist the resident after 10:30 a.m.

A review of the care plan indicated that resident required full support and physical assistance from one staff to complete the daily activity of dressing. [s. 6. (7)]

4. The licensee failed to 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.

Interview with the PSW assigned to the care of an identified resident confirmed that he/she did not have access to the plan of care and was not aware of the resident's plan of care. PSW indicated that he/she referred to a binder for resident's care plan. When inspector asked for the binder, the PSW stated that he/she referred to the resident's chart. The PSW was not able to locate a care plan in the chart except with the assistance of a RPN. PSW also stated that PSWs have access to an electronic plan of care on Kardex, however the inspector noted that the kardex did not include a full care plan for the resident.

PSW confirmed that he/she was not sure about whether the resident was on a specific diet or not. He/she indicated that the resident was receiving nutritional supplement at 2.00 p.m., every day in his/her shift.

A review of the plan of care revealed that resident's diet was an identified specific diet and resident was not receiving any kind of supplement at 2.00 p.m.

Interview with FSM confirmed that the resident was not provided with any kind of supplement at 2.00 p.m.

Interview with ADOC and interim acting ED confirmed that there were care plan binders for PSWs kept at nursing stations. [s. 6. (8)]

5. The licensee failed to 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, the resident's care needs change or care set out in the plan is no longer necessary.

A review of the plan of care for an identified resident revealed that the resident required the use of a mechanical lift and sling when transferred to the toilet as per toileting schedule and as needed, and staff are not to leave resident unattended on toilet.

Interview with PSWs confirmed that they were transferring the resident on the toilet using a sling and a Hoyer lift.

Interview with DOC and ADOC confirmed that the most recent assessment on toileting was conducted for the resident on an identified date by the PT. New recommendation from the reassessment was that resident will no longer be toileted using sling and

Hoyer lift by staff for resident's safety. Resident will be using incontinent products with changes provided by staff in bed. The recommendation was made with the family's agreement. The current plan of care did not reflect the change in the resident's continence care management. [s. 6. (10) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On May 22, 2104, the inspector observed the door to the spa room in an identified unit was ajar and unattended.

Interview with a registered nursing staff confirmed that spa room door should be locked at all times when not in use. [s. 9. (1) 2.]

WN #12: 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.

On May 15, 2014, inspector #210 observed the sofa at the end of the hallway in an identified unit had a spot of dried urine and was smelly. On May 22, 2014, inspector #507 observed the same sofa with smell of urine.

Interview with an identified housekeeping aide and the environmental service manager confirmed that the sofa was smelly and needed to be washed. [s. 15. (2) (a)]

WN #13: 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 appropriate assessment instrument that is specifically designed for assessment of incontinence.

Interview with PSWs and registered nursing staff confirmed that an identified resident was incontinent and using continence product.

A review of the plan of care revealed that the resident was not assessed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Interview with the ADOC confirmed that he/she was only able to find one document in the resident's chart indicating an admission assessment of the size of incontinent product to be used. This assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore functions with specific interventions. [s. 51. (2) (a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing.

Interview with the president of Residents' Council confirmed that he/she had not seen written responses from the home for any concerns raised by the Resident's Council.

A review of Residents' Council meeting minutes for April, 2014, revealed that there were concerns about residents not getting help on the units during general staff meetings, and residents' suggestion to remove wooden divider in the dining room to open up the area.

A review of Residents' Council meeting minutes for March, 2014, revealed that residents raised the following concerns: shortage of blue diapers; fluctuating temperature in the building; staff not closing the doors of residents' rooms after making rounds at nights; and the missing clock and curtain in the tub room of an identified unit.

Interview with the recreation/ volunteer manager confirmed that the home responded to concerns raised by the Residents' Council verbally at the next Residents' Council meeting. There were no written responses provided to the Residents' Council within 10 days by the home after having received the above mentioned concerns. [s. 57. (2)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach and that action was taken and outcomes were evaluated: a change of 10 per cent of body weight, or more, over 6 months.

Record review revealed that RD did not assess an identified resident for significant weight loss of 10% over 6 months. The resident's weight record indicated that resident had a 10% weight loss over 6 month's period.

Interview with the registered nursing staff confirmed that, he/she could not find any documentation to verify that RD assessed the resident for 10% weight loss over 6 month, and if any referral was made for significant weight loss (10%) in May 2014.

Interview with the RD confirmed that he/she did not assess the resident for 10% weight loss over 6 months because he/she did not receive a referral from the registered nursing staff. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items are offered and available at each meal and snack.

Observation made on May 14, 2014, at 12:00 p.m., revealed that the planned gluten free entrée items, honey pork chop and gluten free spaghetti with marinara, were not available for an identified resident who was on gluten free diet.

A review of the gluten free menu revealed that honey pork chop and gluten free spaghetti with marinara should be available for the resident on week 2, Wednesday.

Interview with FSM confirmed that there was a last minute change in the gluten free menu due to unavailability of the planned meal items. Menu items were replaced with chicken and gluten free pasta. [s. 71. (4)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system must, at a minimum, provide for, preparation of all menu items according to the planned menu.

Observation made on May 20, 2014, at 12.00 p.m., revealed a sample plate of salad

with iceberg lettuce on it which was described on the menu as garden salad.

Review of the recipe revealed that garden salad was to include iceberg lettuce, green leaf lettuce, romaine lettuce and shredded carrots.

Interview with the cook confirmed that prepared garden salad had only one kind of lettuce in it. Carrots were not available in the kitchen at the time and therefore carrots were not added to the salad.

Interview with FSM confirmed that garden salad should include leaf lettuce, romaine lettuce and shredded carrots. FSM stated that the delivery from vendor was late that day and therefore some supplies including carrots were not available. [s. 72. (2) (d)]

2. The licensee failed to ensure that all food and fluids in the food production system are prepared using methods to prevent adulteration, contamination and food borne illness.

On May 22, 2014, at 11.30 a.m., inspector #500 observed in the kitchen three bags of frozen tomato sauce lying on the top surface of the steamer. The steamer was on. There was a layer of dust noted on the top surface of the steamer.

Interview with the cook confirmed that tomato bags were left on the steamer for thawing. It was not a safe practice for thawing foods due to risk of cross contamination and adulteration because of the dust deposited on the top surface of the steamer.

Interview with FSM confirmed that the cook should not put bags of tomato sauces on the dusty top surface of the steamer. FSM stated that it was not the proper method for thawing and there was a risk of cross contamination and adulteration due to deposit of dust on the top surface of steamer. [s. 72. (3) (b)]

3. The licensee failed to ensure that the home has and that the staff of the home comply with, a cleaning schedule for the food production, servery and dish washing areas.

Observation conducted on May 20, 2014, 2014, at 1.30. p.m., on second floor serveries revealed that there was dust deposited on the hot water dispensers and coffee machines. The taps of the hot water dispensers were not descaled. Microwaves, fridges and freezers were not cleaned inside and dry food particles were

deposited around the inside walls.

Observation conducted on May 22, 2014, at 11.30 a.m., in the kitchen revealed that there was dust deposited on the top surface of steamer and oven.

Interviews with the cook confirmed that he/she only completed the cleaning when he/she had time, otherwise the cleaning would be postponed to another day.

Interview with dietary staff confirmed that he/she cleaned filters of the coffee machine and wiped off the equipment. He/she did not regularly clean the fridge and freezer inside.

Interview with FSM confirmed that during weekly audit he/she missed the dust deposited on the top surfaces of the equipment. FSM confirmed that freezers in the serveries were used for keeping desserts for meal times only; therefore freezers were not being cleaned regularly. [s. 72. (7) (c)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

Observation conducted on May 27, 2014, at 2 p.m. in an identified resident's room, revealed a bottle of acetone nail polish remover, and a bottle of Providine solution in residents' shared bathroom in a basket on the counter.

Interview with PSW and DOC confirmed that the chemicals should not be kept in room accessible by residents. PSW stated that the bottle of Providine solution was usually kept on the dressing cart used by registered nursing staff. [s. 91.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of the incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

An identified resident fell on an identified date in 2014, and the resident's substitute decision maker (SDM) declined the suggestion to send the resident to the hospital for investigation of altered health condition. Seven days later, the resident was diagnosed with a medical condition that required intervention. Resident's SDM was informed of the condition and refused to send the resident to the hospital for further investigation.

Over the course of the next five weeks, the resident was sent to the hospital with altered health condition on two occasions. The resident's SDM decided to have surgery to remediate the condition, and the surgery was then performed.

Record review revealed and interview with the regional manager of clinical services who was the acting DOC at the time, confirmed that the home did not report the incident to the Director until more than 2 weeks after the surgery was performed on the resident, seven weeks after the home determined that the injury had resulted in a significant change in the resident's health condition. [s. 107. (3)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

1. The licensee failed to ensure the annual evaluation of the medication management system include a review of the quarterly evaluations in the previous year as referred to in section 115.

A review of the annual evaluation of the medication management system conducted on December 16, 2013, and interview with DOC indicated that the annual medication management program evaluation included a review of the pharmacy audit results but did not include a review of the quarterly evaluations of medication incidents for 2013. [s. 116. (3) (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure that the following information is recorded in the drug record of the home in respect of every drug that is received in the home: the date the drug is received in the home, the signature of the person acknowledging receipt of the drug on behalf of the home.

Interview with an identified RPN revealed that drugs were received in the home usually during evening shift and the registered nursing staff were expected to compare the medication pouches with the "Automed report", sign, and date the report.

A review of the drug record book on an identified unit revealed that the "Automed report" dated May 26, 2014, and April 30, 2014, were signed but not dated, the reports from April 25, 2014, and May 6, 2014, were not signed. [s. 133.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

A review of the medication incidents records and interview with the regional manager of clinical services revealed that on March 27, 2014, at the quarterly multidisciplinary resident care committee meeting the medication incidents were reviewed, but not at the quarterly meetings in December and August of 2013. [s. 135. (3)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the requirement that improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents is communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

An interview with the president of the Residents' Council confirmed that the home changed dishes and bowls for meals in December 2013. These changes were not communicated to the Residents' Council. The home introduced new dishes and bowls without informing residents.

An interview with FSM and recreation/volunteer manager confirmed that the replacement of dishes and bowls for meal services were not communicated to the Residents' Council prior to implementation. [s. 228. 3.]

Issued on this 27th day of August, 2014

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

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) :	TILDA HUI (512), MATTHEW CHIU (565), NITAL SHETH (500), SLAVICA VUCKO (210), STELLA NG (507)
Inspection No. / No de l'inspection :	2014_251512_0006
Log No. / Registre no:	T-091-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 11, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	SHERWOOD COURT LONG TERM CARE CENTRE 300 Ravineview Drive, Maple, ON, L6A-3P8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ruth Coleman

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)

Linked to Existing Order / Lien vers ordre existant: 2013_159178_0024, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act.
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Order / Ordre :

The licensee must ensure that by July 15, 2014, the following tasks are completed:
1. provide training based on the licensee's assessment of staff's individual training needs,
2. train identified direct care staff who did not receive the falls prevention and management training in 2013.

Grounds / Motifs :

1. The licensee failed to ensure that direct care staff received annual training in falls prevention and management. An inspection has been conducted on October 15, 2013, inspection # 2013_159178_0024, and a compliance order has been issued for s.221(2) on December 4, 2013, with a compliance date for February 28, 2014.

The licensee was ordered to prepare, submit and implement a plan to ensure that all direct care staff receive training in falls prevention and management annually, or as per their individual training needs based on an assessment conducted by the licensee.

The licensee submitted the plan to the Ministry on December 20, 2013, which includes the following plan of actions:

1. Staff who were identified as not having received falls prevention and management training in 2013 will receive falls prevention and management training by February 28, 2014.

Record review revealed and staff interview confirmed that 34 direct care staff identified did not receive falls prevention and management training in 2013. Five direct care staff (16%) did not receive the training as per the compliance date of February 28, 2014.

2. Short-term plan of actions include conducting training needs assessment with staff annually and establish a falls committee.

Record review revealed and staff interview confirmed that the training needs assessment with staff had not been conducted, and the falls committee had not been established as of May 23, 2014.

(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 15, 2014

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

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 11th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tilda Hui

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