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 21, 2014	2014_253514_0019	L-000662-14	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

TRILLIUM COURT
550 PHILIP PLACE, KINCARDINE, ON, N2Z-3A6

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

RUTHANNE LOBB (514), BONNIE MACDONALD (135), JUNE OSBORN (105), RUTH HILDEBRAND (128)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11, 12, 13, 16, 17, 18, 19, 2014

Inspector #135 joined the RQI team June 17, 18, 19, 2014.
This inspection was done in conjunction with Critical Incident Inspections, completed by Inspector #135, Log #L-000373-14, Log#L-000561-14.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Regional Manager of Education and Resident Services, Regional Manager of Clinical Services, Director of Care, Food Services Manager, Environmental Services Manager, Resident Assessment Coordinator, Education Coordinator, Recreation Manager, Office Manager, 1 Registered Nurse, 4 Registered Practical Nurses, 9 Personal Support Workers, 5 Family Members, 1 Restorative Care Aide, 1 Physiotherapy Aide, 1 Housekeeping Aide, 2 Students, 2 Cooks, 1 Assistant Cook, 3 Dietary Aides,5 Family Members and 20+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident and common areas, observed residents and the care provided to them and observed meal service. Medication administration and storage were observed and the clinical records for identified residents were reviewed. Policies and procedures of the home were reviewed along with observation of general maintenance and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Recreation and Social Activities
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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement, as evidenced by:

On June 18, 2014, a review of the Registered Staff Schedule, revealed 21/28 (75%) evening shifts (15:00-23:00 hours) from May 17-June 13, 2014 had no on-site Registered Nursing coverage.

On June 18, 2014 at 10:00 hours, an interview with the Director of Care confirmed the following:

a) 21/28 evening shifts (15:00-23:00) from May 17-June 13, 2014 had no Registered Nursing staff on-site.
b) On May 28, June 1, June 6, 2014 there were no Registered Nursing staff on-site from 07:00-23:00.
c) Registered Nursing staff provide off site, on call coverage for the home when there is no Registered Nursing staff on-site.

On June 13, 2014 at 13:30, interview with the Director of Care revealed that the home utilized agency Registered Nurses for some registered nursing staff coverage during the months of April and May, 2014. It was confirmed by the Director of Care that effective May 31, 2014, the home opted to no longer utilize agency staffing. The Director of Care verified that currently the home has two registered nursing positions vacant with anticipated coverage of these positions in July, 2014.

There has been a previous Written Notification and Compliance Order for LTCHA, 2007 S.O. 2007, c.8, s.8.(3), issued on April 24, 2013, 2013_181105_0014 and complied on July 4, 2013, 2013_181105_0032.

There has been a previous Written Notification and Voluntary Plan of Correction for LTCHA, 2007 S.O. 2007, c.8, s.8.(3) issued on November 8, 2012, 2012_182128_0003. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:(b) complied with, as evidenced by:

a) A review of the home's Medication/Treatment Standards, Psychotropic Medications LTC-F-160, April 2013, revealed that the policy was not complied with.

On June 17, 2014 at 12:00, the Director of Care and a Registered Nursing staff member confirmed that the home is not following their policy Medication/Treatment Standards, Psychotropic Medications LTC-F-160, April 2013, as currently no residents that are admitted or that are currently receiving psychotropic medication(s) have an assessment completed that includes an assessment of the clinical or environmental factors that may be affecting the responsive behaviours using the ABC model for understanding behaviour; initiation of behavioural mapping to observe and monitor patterns of behaviour; review of clinical history for evidence and effectiveness of non-pharmacological interventions that may have been trialed; and specific identification of the target behaviour being treated if psychotropic medications are utilized.

The Director of Care and a Registered Staff member could not identify where the home's Dementia Resource Binder was located as referenced in the home's policy, Medication/Treatment Standards Psychotropic Medication LTC-F-160, April 2013.

On June 19, 2014 at 09:30, during an interview with a Registered Nurse and a Registered Practical Nurse, they confirmed that the home is currently not monitoring psychotropic medication effectiveness and although they were able to provide one "Monitoring for Medication Effectiveness" form on a clip board, they identified that documentation on the form had been last completed on January 17, 2014 and there were no resident identifiers on the form.

b) A review of Medication Treatment Standards, Psychotropic Medications LTC-F-160, revision date April 2013, states that the interdisciplinary team, in collaboration with the Physician or Nursing Practitioner, will have a formalized and regularly scheduled psychotropic medication monitoring, review and documentation process in place for assessment of the ongoing need for medication(s).
A Registered Nurse and a Registered Practical Nurse confirmed that currently there is no formalized and regularly scheduled psychotropic medication monitoring, review and documentation process in place by an interdisciplinary team.

On June 19, 2014, the Director of Care verified that the home is currently not monitoring the effectiveness and documenting the residents` response and effectiveness of psychotropic medications and confirmed the home`s expectation that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. [s. 8. (1) (a),s. 8. (1) (b)]

2. An identified resident had an adverse event.

A review of the home’s Adverse Event Management policy LP-C-40 April 2013, revealed that the policy was not complied with.
The policy states:
All adverse events will be documented according to an established process using the Resident Incident Report form (Lp-C-40-05).

a) Record review revealed that the home did not document the adverse event, using the Resident Incident Report form (Lp-C-40-05).

b) During record review, it was revealed that a registered staff member reported that the Personal Support Worker had called for assistance during the adverse event,

using her "walkie talkie" phone, but it did not work.

On June 18, 2014, an interview with the Environmental Services Manager, revealed that the home could not verify if the Personal Support Worker's "walkie talkie" was working during or after the adverse event and the home was unable to provide documentation of assessment and/or repair of the "walkie talkie" equipment.

c) An interview with the Food Services Manager revealed that the home could not provide documentation to verify, and could not confirm, if the resident had received the correct diet on the identified date that the adverse event occurred.

During an interview, the Executive Director confirmed that the identified incident was an adverse event, and it is the home's expectation that the Adverse Event Management Policy LP-C-40, April 2013, be complied with ensuring that adverse events are documented using the Resident Incident Report form. [s. 8. (1) (a),s. 8. (1) (b)]

3. A review of the home's Employee Influenza Vaccine Policy HR-D-80, June 2013, revealed that the policy was not complied with.
The policy states:
During a confirmed Influenza outbreak an employee who chooses to refuse immunization and/or antiviral medications, will remain off work until the following occurs:
#2-Employees must provide proof (physicians note or medical documentation) of receiving the flu vaccine or, when applicable, receiving antiviral prophylaxis, to their manager before resuming their duties.

April 7, 2014 to April 21, 2014, the home had a confirmed outbreak of Influenza A.

Record review with the Resident Assessment Instrument Coordinator revealed that 10 of the registered and non-registered staff had refused immunization for influenza.

In an interview with the Director of Care, it was confirmed that the 10 registered and non-registered staff had not provided proof (physicians note or medical documentation) of receiving the flu vaccine or receiving antiviral prophylaxis, before resuming their duties during the outbreak of Influenza A, April 7, 2014 to April 21, 2014.

During an interview the Director of Care confirmed her expectations that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with, related to staff immunization policy. [s. 8. (1)]

4. On June 11, 2014, a lunch meal tray was observed being carried down the hall with the beverages uncovered.
A review of the Tray Service - Ontario only policy, revision date February 2012, revealed that the policy was not complied with.
The policy states:
The safe food handling procedure should be followed according to Food Safety guidelines. The meal will be kept at an appropriate temperature and all food items must be covered properly.

The Food Services Manager indicated that the expectation was that all food and beverages were covered on trays and acknowledged that the policy was not complied with. [s. 8. (1)]

5. On June 18, 2014, a review of the home's Environmental Services Calendar of Continuous Quality Improvement Activities, Residents' Rooms Housekeeping Audit, CQI-I-80, Revision date, July 2007, revealed that the home's expectation is the Residents' Rooms Housekeeping Audit will be conducted annually to ensure that all residents' rooms are cleaned in accordance with regulatory requirements.

The Environmental Services Manager confirmed that annual audits of residents' rooms have not been completed and are not currently being completed in the home. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 was a safe and secure environment for its residents, as evidenced by:

On June 19, 2014, an inspector was able to enter the elevator, and go to the basement by using the key which was hanging on a nail outside the elevator and the following safety risks were noted:
The exterior door to the back of the building was unlocked and unattended.
There was also a SW stairwell that had an unlocked door to the exterior of the building.
The maintenance room was unlocked and unattended and contained saw, hammers, screw drivers, pliers and other maintenance tools.
An unlocked and unattended storage room contained an electrical panel.

The Regional Manager of Clinical Services confirmed these observations and acknowledged that these safety risks needed to be attended to immediately as residents should not have access to the exterior of the building. She also locked the doors of both the maintenance room and storage room.

The elevator key was removed prior to the inspectors leaving the building. [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 to ensure that the home is a safe and secure environment for its residents,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for, an identified resident that sets out clear directions to staff and others who provide direct care to the resident.

The Care Plan included the required need for assistance for maximum self sufficiency related to mouth care. The interventions do not include any directions to staff regarding mouth care.

A Registered Practical Nurse confirmed the Care Plan did not provide clear direction

to the staff concerning mouthcare , since the current practice was not documented.

The Director of Care verified the Care Plan did not provide clear direction to the staff concerning mouth care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the care plan for an identified resident is based on an assessment of their needs.

A medical record review revealed that an identified resident was assessed. The Resident Assessment Instrument assessment triggered Resident Assessment Protocols indicated that with the urinary incontinence this resident was experiencing, a toileting routine would be considered beneficial in avoiding complications.

There is no toileting routine mentioned in the Care Plan.

The Director of Care confirmed there is no toileting routine mentioned as part of the Care Plan. [s. 6. (2)]

3. The licensee has failed to 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.

The medical record review revealed the assessment completed by physiotherapy related to Range of Motion for an identified resident was last completed in July 2013. The Resident Assessment Instrument assessments have indicated a decline in Range of Motion from July to October 2013.

An activation aide shared that the identified resident does not get Range of Motion Exercises from them.

The Director of Care confirms the physiotherapy program has not provided Range of Motion exercises since July 2013, and currently the resident is not receiving Range of Motion exercises in the home since there was no collaboration between the outgoing physiotherapy and either the restorative care department, or the staff doing the Resident Assessment Instrument assessments replacing the therapy assessment. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when an identified resident's care needs have changed.

A medical record review revealed an identified resident had a change of care status and the recreation care plan has no revisions written to reflect this change of care needs.

The Recreation Manager confirmed the Care Plan was not revised when the resident's care needs changed. [s. 6. (10) (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 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 residents; that is based on an assessment of the residents' needs; that staff and others involved in the different aspects of care of the resident collaborate with each other; and that the resident is reassessed and the plan of care reviewed and revised when resident care needs change,, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, as evidenced by:

On June 13, 2014,at 12:20, observations of the tub room revealed the following housekeeping issues:
-build-up of dust on the floor in the shower and an accumulation of dust and debris in the shower drain;
-soil and debris on the tub room floor;
-the fan had a build-up of dust on it;
-the wall under the sink had a white film on it.

The administrator viewed and confirmed the above housekeeping observations. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

Room A - Paint chipped off of lower right door frame, 6 centimetres in length.

Room B - Paint chipped off of lower left and right door frame. Paint scratched and chipped off of bathroom door frame.

Room C - Paint chipped off of lower right door frame. Piece of baseboard, 8 centimetres in length missing by bathroom door frame.

Room D - Paint chipped off of left door frame and right bathroom door frame.

Room E - Piece of baseboard, 5 centimetres in length off of wall by bathroom door frame.

Room F - Paint chipped off of lower bathroom door frame.

Hydrotherapy Room - Paint chipped off of lower left and right door frame.

Dining Room door on back hallway - Baseboard has pulled away from right door frame, 4 centimetres in length. Drywall cracked and gouged for 14 centimetres in length by left back hall dining room door.

Drywall damage on back hallway by the second dining room door, left lower door frame, baseboard pulling away 5 centimetres on lower left back hallway dining door.

Room G - Paint chipped off of lower right door frame and paint chipped off of lower left and right bathroom door. Plaster damage by bed 3, 14 centimetres in length. Radiator by bed 3 is rusted and there is paint off the wall above the radiator.

Room H - Door frame into washroom is scratched through the paint near the bottom. The wall beside bed 2 is heavily damaged with scratches and plaster chipped from the corner, up the wall and around the corner at the foot of the resident's bed. Baseboard is coming off at the head of the bed by the closet. The radiator is scratched.

Main exit door of nursing home has significant areas scratched and paint chipped off.

On June 13, 2014, at 12:20, observations of the tub room revealed the following maintenance issues:
-water was leaking from the sink;
-the tub had a rust stain on it; and
-paint was chipped off the closet door (128)

On June 18, 2014, the Environmental Services Manager verified the above noted rooms needing maintenance repair and confirmed the home's expectation that the resident rooms and common areas are to be maintained in a good state of repair. The Environmental Services Manager confirmed that no resident room audits for room repairs were being completed. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The home has failed to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessment and interventions and that the resident's responses to interventions are documented, as evidenced by:

On June 17, 2014, a review of clinical data for three identified residents revealed no documented evidence of assessment or reassessment of responsive behaviours.

The Director of Care confirmed that there was no assessment or reassessment of responsive behaviours completed for these three identified residents.

On June 17, 2014, the Director of Care confirmed that the home is not following their home policy on Responsive Behaviours LTC-E-100 Revision date, August 2012 as all residents experiencing challenging or disruptive responsive behaviours have not had a comprehensive assessment using a validated tool; the S.T.O.P Aggressive Responsive Behaviours tool is not being used as a resource to manage disruptive and or aggressive behaviours; and the home is not using the Dementia Observation System (DOS) tracking tool to monitor responsive behaviours.

The Director of Care verified that the home has failed to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident,including assessments, reassessment and interventions and that the resident's responses to interventions are documented. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessment and interventions and that the resident's responses to interventions are documented,, to be implemented voluntarily.

WN #7: 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 has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations as evidenced by:

On June 18, 1014 at 11:30, a review of the Resident Council Constitution, revision date, January 2011, revealed that the Administration should respond to the concerns and requests presented by Resident's Council Committee within 7 days.

A review of the home's Standardized Resident's Council Concerns form, revealed that "Action Taken or Response to the Residents' Council concern is to be completed within 21 days and presented to the Residents' Council for their review and response".

A review of the Residents' Council Concerns form, initially completed at the Residents' Council Meeting on May 1, 2014, revealed that the written response to the Residents' Council's concerns or recommendations was completed and dated May 20, 2014.

The Administrator confirmed that this written response completed for the Residents' Council, dated May 20, 2014, exceeded the required response time of 10 days. [s. 57. (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 the licensee responds within 10 days of receiving Residents' Council advice related to concerns or recommendations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that heights are taken upon admission and annually thereafter, as part of the weight monitoring system, as evidenced by:

Clinical record reviews and staff interviews with registered staff revealed the following:
-9 of 37 residents (24%) reviewed, did not have a height recorded; and
-20 of 37 residents (54%) reviewed, had not had a height taken since 2012.

The Director of Care indicated that the expectation is that heights are taken upon admission and annually thereafter. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that heights are taken upon admission and annually thereafter, as part of the weight monitoring system, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, during dining and snack services, as evidenced by:

a) On June 12, 2014, an identified resident was observed being assisted with drinking. The resident was not in a safe position and this was placing the resident at potential choking risk. Additionally, the resident was seated at approximately a 78 degree angle. The resident was coughing while being assisted with drinking.

The Director of Care confirmed an identified resident was not at a safe feeding height.

b) On June 19, 2014, another identified resident was observed being assisted with drinking, by a Restorative Care Aide, in front of the nursing station. The Aide was standing at least 12 inches higher than eye level, placing the resident at potential choking risk related to the unsafe position. The Restorative Care Aide acknowledged that she had probably been told about safe feeding practices.

The Director of Care confirmed that the expectation was that all residents who require assistance with eating were expected to be in a safe position while being assisted. [s. 73. (1) 10.]

2. The licensee has failed to ensure that there were appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and tables at appropriate height to meet the needs of all residents, as evidenced by:

On June 11, 2014, during the lunch meal service, 4 residents were observed eating their meals on the table trays of their wheelchairs. A Registered Practical Nurse confirmed that the residents were not seated at tables at an appropriate height to meet their needs.

The Food Services Manager confirmed the expectation is that residents are seated at tables that are an appropriate height. [s. 73. (1) 11.]

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 appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and tables at an appropriate height to meet the needs of all residents, are provided; and to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, during dining and snack services, to be implemented voluntarily.

WN #10: 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 has failed to ensure that hazardous substances at the home are kept inaccessible to residents at all times, as evidenced by:

a) On June 13, 2014, at 12:20, the tub room was observed unlocked and unattended. The closet in the tub room was also unlocked and contained hazardous chemicals including "fancy scrub blue" and Ecolab bathroom cleaner. A Personal Support Worker confirmed that the tub room was unlocked and unattended.

The Administrator revealed that the expectation is that the tub room was supposed to be locked when unattended and that hazardous chemicals should not be accessible to residents.

b) On June 19, 2014, at 14:15, while accessing the basement, an inspector observed the following risks related to hazardous substances being accessible to residents:

The unlocked and unattended "outside storage room" contained 30 x 5 Gallon pails of hazardous substances, including dishwashing chemicals and 7 x 5 Litre jugs of chemicals.

The garbage room was unlocked and unattended and contained hazardous chemicals, on a housekeeping cart, including Easy scrub blue, toilet bowl cleaner, washroom cleaner, and glass and & surface cleaner.

The Regional Manager of Clinical Services confirmed these observations and indicated that they needed to be attended to immediately. She locked the outside storage room and the garbage room. She acknowledged the expectation was that hazardous substances were kept inaccessible to residents at all times. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times,, to be implemented voluntarily.

WN #11: 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. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked, as evidenced by:

On June 13, 2014, at 08:07, an unlocked and unattended medication cart was observed. There were two residents sitting in the hallway near the cart. A Registered Practical Nurse acknowledged that the cart should have been locked as it was unattended.

The Director of Care stated that the expectation was that medication carts were to be locked when unattended. [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 to ensure that drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #12: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

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:
2. Residents must be offered immunization against influenza at the appropriate time each year. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program, as evidenced by:

On June 12, 2014, an upright fan was observed in the dining room to have very dusty fan openings, blowing toward a resident dining table. Additionally, a blade fan in the dining room was found to be very dusty, as well as 2 upright fans in the front hallway. According to the housekeeping staff, the person who used to clean fans, no longer is at the home.

These observations were verified by the Director Of Care, the Administrator and the Regional Manager of Clinical Services. The fans were gathered and cleaned immediately. [s. 229. (4)]

2. The following unlabelled or improperly stored personal care items were observed in resident

washrooms June 11-13, 2014:

Room I - labelled urine collection hat with a small amount of urine in it sitting on the floor beside the toilet in the shared washroom.

Room J - unlabelled bed pan in the shared washroom.

Room K - bed pan observed on floor of the washroom.

Room L - bed pan labelled with female resident name observed sitting on floor of a shared male washroom.

Room M - unlabelled bed pan sitting on floor beside toilet in the shared washroom.

Tub room inspection conducted, June 13, 2014, at 12:20, revealed that there were 3 unlabelled pairs of nail clippers, a roll on deodorant, and 2 unlabelled hair brushes in the open closet. A bed pan was also observed sitting on the floor.

The Administrator confirmed the observations and indicated that personal care items should not be used for communal use and bed pans should not be stored on the floor. She threw the hair brushes, and the roll on deodorant into the garbage and removed the unlabelled nail clippers from the room.

The Director of Care confirmed the expectation is that all personal care items are to be labelled in shared washrooms. [s. 229. (4)]

3. On June 11, 2014, at the lunch meal, a Personal Support Worker was observed, clearing plates and then washing the face of a resident, and assisting another resident without evidence of hand hygiene/hand washing observed in-between. The Personal Support Worker then assisted two other residents with eating, touching cutlery and glasses with no evidence of hand hygiene in-between.
The Personal Support Worker acknowledged that hand hygiene/hand washing should have been done after touching dirty items and before assisting residents.

The Food Services Manager acknowledged that the expectation is that staff are expected to wash their hands/use hand hygiene between touching dirty items and assisting residents. [s. 229. (4)]

4. Record review with the Infection Control Lead Registered Nurse, revealed that of 4 residents admitted to the home during an identified time period, 1 resident or 25% of the residents reviewed, did not have tuberculosis screening within 14 days of admission.

During an interview, the Director of Care confirmed her expectations that when residents are admitted to the home they are 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. [s. 229. (10) 1.]

5. Record review with the Infection Control Lead Registered Nurse revealed that of 4 residents admitted to the home during an identified time period, 1 resident or 25% of the residents reviewed, were not offered immunization against influenza.

During an interview, the Director of Care confirmed her expectations that all residents are offered immunization against influenza at the appropriate time of the year. [s. 229. (10) 2.]

6. Record review with the Infection Control Lead, Registered Nurse, revealed that 3 residents out of 4, or 75% of the residents, were not offered immunization against pneumoccocus and 2 residents, out of 4 residents, or 50% of the residents that were admitted to the home during an identified time period, were not offered immunizations against tetanus and diphtheria, in accordance with the publicly funded immunization schedules.

During an interview, the Director of Care confirmed her expectations that all residents are offered immunization against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 4. Mission statement

Specifically failed to comply with the following:

s. 4. (3) The licensee shall ensure that the mission statement is developed, and revised as necessary, in collaboration with the Residents' Council and the Family Council, if any, and shall invite the staff of the long-term care home and volunteers to participate. 2007, c. 8, s. 4. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the mission statement was developed, and revised as necessary, in collaboration with the Residents' Council and failed to invite staff of the long-term care home and volunteers to participate, as evidenced by:

On June 18, 2014, interviews with 2 Resident Council Committee members and 2 staff confirmed that the home's mission statement was not developed, and revised as necessary, in collaboration with the Residents' Council, and did not invite staff of the long-term care home and volunteers to participate.

On June 18, 2014, the Administrator confirmed that Trillium Court Mission, Values and Pledge was the home's Corporate Mission, Pledge and Values Statement. The Administrator confirmed that the home's mission statement was not developed, and revised as necessary, in collaboration with the Residents' Council and the Family Council, if any, and did not invite staff of the long-term care home and volunteers to participate. [s. 4. (3)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, as evidenced by:

On June 12, 2014, windows in the following resident rooms were observed to open more than 15 centimetres:

Room N - exterior window opened 20 centimetres;
Room O - exterior window opened 22 centimetres;
Room P – exterior window opened 22 centimetres;
Room Q - exterior window opened 60 centimetres;
Activity Room - exterior window #1 opened 60 cm, exterior window #2 opened 20 centimetres. (514)

The Administrator acknowledged that this was a safety risk and stated that the windows should open only 4 inches. Within a half hour of the Administrator being informed of the risk, all identified windows had been fixed and "limiters" had been placed on all of them. The Administrator indicated that the home would check the rest of the windows to ensure compliance. [s. 16.]

WN #15: 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 has 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, as evidenced by:

a) On June 12, 2014 at 10:35, a call bell was observed hanging down behind the bed and an identified resident was seen sitting in the middle of the room looking out the window.

A Registered Nurse confirmed this observation and gave the resident the call bell.

b) On June 13, 2014, at 11:31, a call bell was observed to be attached to an identified resident but the resident was unable to activate the call bell independently due to the length of the call bell cording.

The Director of Care confirmed that the resident would be unable to activate the call bell independently and the maintenance staff shortened the call bell cord. [s. 17. (1) (a)]

Issued on this 30th 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) :	RUTHANNE LOBB (514), BONNIE MACDONALD (135), JUNE OSBORN (105), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2014_253514_0019
Log No. / Registre no:	L-000662-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 21, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	TRILLIUM COURT 550 PHILIP PLACE, KINCARDINE, ON, N2Z-3A6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lynda Good

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

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with 2007, c. 8, s. 8 (3) to ensure at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Please submit the plan in writing to Ruthanne Lobb, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 130 Dufferin Avenue, 4th floor, London ON N6A 5R2, by email, at Ruthanne.Lobb@ontario.ca by August 15, 2014.

Grounds / Motifs :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement, as evidenced by:

On June 18, 2014, a review of the Registered Staff Schedule, revealed 21/28 (75%) evening shifts (15:00-23:00 hours) from May 17-June 13, 2014 had no on-site Registered Nursing coverage.

On June 18, 2014 at 10:00 hours, an interview with the Director of Care confirmed the following:

a) 21/28 evening shifts (15:00-23:00) from May 17-June 13, 2014 had no Registered Nursing staff on-site.
b) On May 28, June 1, June 6, 2014 there were no Registered Nursing staff on-site from 07:00-23:00.
c) Registered Nursing staff provide off site, on call coverage for the home when there is no Registered Nursing staff on-site.

On June 13, 2014 at 13:30, interview with the Director of Care revealed that the home utilized agency Registered Nurses for some registered nursing staff coverage during the months of April and May, 2014. It was confirmed by the Director of Care that effective May 31, 2014, the home opted to no longer utilize agency staffing. The Director of Care verified that currently the home has two registered nursing positions vacant with anticipated coverage of these positions in July, 2014.

There has been a previous Written Notification and Compliance Order for LTCHA, 2007 S.O. 2007, c.8, s.8.(3), issued on April 24, 2013, 2013_181105_0014 and complied on July 4, 2013, 2013_181105_0032.

There has been a previous Written Notification and Voluntary Plan of Correction for LTCHA, 2007 S.O. 2007, c.8, s.8.(3) issued on November 8, 2012, 2012_182128_0003.

(514)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must achieve compliance with O. Reg. 79/10, s.8.(1) (b) to ensure that the following policies are implemented in accordance with applicable requirements under the Act and that they are complied with,
The following home policies are to be complied with:
a) Tray Service - Ontario only policy, revision date February 2012
b) Employee Influenza Vaccine Policy HR-D-80, June 2013
c) Adverse Event Management Policy LP-C-40, April 2013
d) Medication/Treatment Standards, Psychotropic Medications LTC-F-160, April 2013
e) Environmental Services Calendar of Continuous Quality Improvement Activities, Residents' Rooms Housekeeping Audit, CQI-I-80, revision date, July 2007

Grounds / Motifs :

1. On June 11, 2014, a lunch meal tray was observed being carried down the hall with the beverages uncovered.
A review of the Tray Service - Ontario only policy, revised date February 2012, revealed that the policy was not complied with.
The policy states:
The safe food handling procedure should be followed according to Food Safety guidelines. The meal will be kept at an appropriate temperature and all food items must be covered properly.
The Nutrition Manager indicated that the expectation was that all food and

beverages were covered on trays and acknowledged that the policy was not complied with.
(128)

2. A review of the home's Employee Influenza Vaccine Policy HR-D-80, June 2013, revealed that the policy was not complied with.
The policy states:
During a confirmed Influenza outbreak an employee who chooses to refuse immunization and/or antiviral medications, will remain off work until the following occurs:
#2-Employees must provide proof (physicians note or medical documentation) of receiving the flu vaccine or, when applicable, receiving antiviral prophylaxis, to their manager before resuming their duties.

April 7, 2014 to April 21, 2014, the home had a confirmed outbreak of Influenza A.

Record review with the Resident Assessment Instrument Coordinator revealed that 10 of the registered and non-registered staff had refused immunization for influenza.

In an interview with the Director of Care, it was confirmed that the 10 registered and non-registered staff had not provided proof (physicians note or medical documentation) of receiving the flu vaccine or receiving antiviral prophylaxis, before resuming their duties during the outbreak of Influenza A, April 7, 2014 to April 21, 2014.

During an interview the Director of Care confirmed her expectations that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place, is complied with, related to staff immunization policy. (135)

3. An identified resident had an adverse event with a negative outcome.

A review of the home's Adverse Event Management policy LP-C-40 April 2013, revealed that the policy was not complied with.
The policy states:
All adverse events will be documented according to an established process using the Resident Incident Report form (Lp-C-40-05).

a) Record review revealed that the home did not document the adverse event, using the Resident Incident Report form (Lp-C-40-05).

b) During record review, it was revealed that a registered staff member reported that the Personal Support Worker had called for assistance during the adverse event, using her “walkie talkie” phone, but it did not work.

On June 18, 2014, an interview with the Environmental Services Manager, revealed that the home could not verify if the Personal Support Worker's "walkie talkie" was working during or after the adverse event and the home was unable to provide documentation of assessment and/or repair of the "walkie talkie" equipment.

c) An interview with the Food Services Manager revealed that the home could not provide documentation to verify, and could not confirm, if the resident had received the correct diet on the identified date of the adverse event.

During an interview, the Executive Director confirmed that this identified incident, was an adverse event, and it is the home's expectation that the Adverse Event Management Policy LP-C-40, April 2013, should have been complied with during this adverse event, and should be complied with, when any adverse event occurs. (135)

4. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:(b) complied with, as evidenced by:

a) A review of the home’s Medication/Treatment Standards, Psychotropic Medications LTC-F-160, April 2013, revealed that the policy was not complied with.

On June 17, 2014 at 12:00, the Director of Care and a Registered Nursing staff member confirmed that the home is not following their policy Medication/Treatment Standards, Psychotropic Medications LTC-F-160, April 2013, as currently no residents that are admitted or that are currently receiving psychotropic medication(s) have an assessment completed that includes an assessment of the clinical or environmental factors that may be affecting the responsive behaviours using the ABC model for understanding behaviour; initiation of behavioural mapping to observe and monitor patterns of behaviour;

review of clinical history for evidence and effectiveness of non-pharmacological interventions that may have been trialed; and specific identification of the target behaviour being treated if psychotropic medications are utilized.

The Director of Care and a Registered Staff member could not identify where the home's Dementia Resource Binder was located as referenced in the home's policy, Medication/Treatment Standards Psychotropic Medication LTC-F-160, April 2013.

On June 19, 2014 at 09:30, during an interview with a Registered Nurse and a Registered Practical Nurse, they confirmed that the home is currently not monitoring psychotropic medication effectiveness and although they were able to provide one "Monitoring for Medication Effectiveness" form on a clip board, they identified that documentation on the form had been last completed on January 17, 2014 and there were no resident identifiers on the form.

b) A review of Medication Treatment Standards, Psychotropic Medications LTC-F-160, revision date April 2013, states that the interdisciplinary team, in collaboration with the Physician or Nursing Practitioner, will have a formalized and regularly scheduled psychotropic medication monitoring, review and documentation process in place for assessment of the ongoing need for medication(s).
A Registered Nurse and a Registered Practical Nurse confirmed that currently there is no formalized and regularly scheduled psychotropic medication monitoring, review and documentation process in place by an interdisciplinary team.

On June 19, 2014, the Director of Care verified that the home is currently not monitoring the effectiveness and documenting the residents` response and effectiveness of psychotropic medications and confirmed the home`s expectation that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs. (514)

5. On June 18, 2014, a review of the home's Environmental Services Calendar of Continuous Quality Improvement Activities, Residents' Rooms Housekeeping Audit, CQI-I-80, Revision date, July 2007, revealed that the home's expectation is the Residents' Rooms Housekeeping Audit will be conducted annually to

ensure that all residents' rooms are cleaned in accordance with regulatory requirements.

The Environmental Services Manager confirmed that annual housekeeping audits of residents' rooms are not being completed in the home at this time. (514)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2014

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 21st day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ruthanne Lobb

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