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

Division de la responsabilisation et de la performance du système de santé
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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
Aug 23, 2013	2013_208141_0016	H-000287-13	Complaint

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

SHARLEE MCNALLY (141), BERNADETTE SUSNIK (120), CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 10, 11, 12, 13, 14, 20, 2013

This report also includes Complaint Log #H-000219-13, H-000304-13, H-000307-13, H-00033-13

During the course of the inspection, the inspector(s) spoke with The Administrator, the Assistant Director of Care (ADOC), the Director of Education Services, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSWs), Housekeeping staff, Maintenance Supervisor, Dietary Aides, Dietitian, Receptionist, families and residents.

During the course of the inspection, the inspector(s) observed resident care and dining service; completed inspections of residents rooms and personal care equipment; and reviewed resident's records, home's policies and procedures, and complaint and maintenance log; staff work schedules.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Infection Prevention and Control

Nutrition and Hydration

Personal Support Services

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Resident #003 was not properly cared for in a manner consistent with his or her needs.
The resident was identified on a specific date to have an acute change in medical status. The registered staff did an initial examination of the resident and confirmed the symptoms. There was no change in the resident's plan of care. The physician was not contacted about the resident's change and the SDM was not contacted for more than two hours. Staff confirmed there was no instructions provided by the registered staff for changing the residents plan of care related to change in medical status. The resident's records did not indicate the registered staff provided direction to PSWs in change of resident care needs or take action in response to change in medical status.
The resident was diagnosed by the hospital with a newly identified medical condition. Contact with the hospital by the home confirmed the resident had a change in care needs related to the diagnosis. [s. 3. (1) 4.]

2. Residents receiving treatment for diabetes were not afforded privacy for testing of blood sugars on administration of insulin by injection.
A)An Inspector observed in the resident dining room on June 12, 2013, a RN standing with a medication cart. The RN stated the cart was used for blood sugar testing and insulin administration. The RN further stated they were aware that the treatments should be done in privacy but many of the residents bring themselves to the dining room before 1130 hours and the staff cannot get them to wait in their rooms, therefore the staff have no choice but to give the treatments in the dining room in the presence of other residents.
B)On June 12, 2013 an inspector observed while in the dining room during the evening meal:
i) A RN check resident #0012 blood sugar at the table at 1650 hours.
ii) A RN administer injectable insulin to resident #0011 in the dining room.
iii) A RPN was observed administering insulin to residents #013, #014, #102, and #006 in the dining room at their respective tables from 1650 hours to 1710 hour.
C) On June 13, 2013, the RN on the day shift confirmed they had administered the lunch insulins and completed the blood sugar testing. The RN stated they had administered five insulins and seven glucometer testings. The RN identified the following
i) Resident #0011 was administered insulin in the hall in front of other residents. The resident had been instructed to wait in their room but had come down to the hall outside the dining room.

ii) Resident #0013 was administered insulin in the activity room in presence of other residents. The resident had been in the room to attend a program and their bedroom was too far away and there was too many residents outside in the hall to direct the resident through.
Staff confirmed there were areas near the dining room that could afford privacy for the testing of blood sugars and administration of insulin but privacy had not been respected. [s. 3. (1) 8.]

3. Residents who have received a bath using an identified spa room between June 10 and June 14, 2013 were not afforded the right to privacy. According to staff, the spa room has not had a privacy curtain for many months.
The tub located in the identified spa room was not equipped with a privacy curtain so that residents could be given complete privacy while bathing and while getting dressed. The door to the tub room when opened, offers a direct line of sight to residents while in the tub or while being dressed. The spa room also has a toilet area and a shower area, which according to staff, is used by other residents while a resident is being bathed. [s. 3. (1) 8.]

4. Resident #001 rights were not fully respected and promoted in respect to the revision of their plan of care. The resident's progress notes on an identified date indicated their Power of Attorney (POA) requested to have the resident placed back in bed at specific time of day with specific direction for the bed positioning. On a later identified date, the POA informed to the Administrator they had observed the resident in bed with incorrect positioning. The Administrator responded to the POA's concern in writing acknowledging the POAs request. The resident's current Plan of Care identified the POA's request for the resident to be placed in bed at a specific time but did not provide direction for the bed positioning.
The resident's comfort was not identified and choices respected in provision of care. [s. 3. (1) 11. i.]

5. Resident #001 did not have their right of choice for bathing promoted or respected. The resident was admitted in 2013. The resident's POA had requested the resident receive tub baths as the choice of preference for bathing. The residents records identified the resident had received alternate methods of bathing in place of tub baths on multiple occasions without identified medical reasons for the change.
The POA complained to the home concerning the resident not receiving bathing of their preference. The home responded in writing stating the Ministry of Health and

Long Term Care guidelines offer a shower, tub or full body sponge bath as options for resident on their scheduled bath day. Their documentation supports that alternate methods of bathing were given to the resident the week in question.
The resident's plan of care at time of the inspection did not identify the resident's preference for bathing. The Administrator confirmed that the bathing preference should be identified on the home's bathing sheets. [s. 3. (1) 19.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 did not ensure that the resident, the resident's substitute decision-maker, were given an opportunity to participate fully in the development and implementation of the resident's plan of care.
On an identified date resident #003 was reported to have an acute change in medical status. The resident was initially assessed, but the SDM was not notified of resident's acute change in status. The SDM was telephoned two hours later and informed of the event. The SDM instructed the resident be sent to hospital for an assessment. The SDM stated if they had been informed at the time of the event they would have given the instruction for transfer at that time. The ADOC confirmed the SDM should of been notified at the time the change in status of the resident was identified.
Resident #003 Substitute Decision Maker (SDM) was not given the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. Care was not provided to resident #0023 as set out in their plan of care on both June 11 and 12, 2013.
The inspector on both days responded to the resident verbalizing a need related to continence. No staff could be located at the time of either incident. The resident was assisted to the toilet by the inspector on both dates. While in the washroom, the resident expressed their need for physical guidance.
A PSW who provided care identified responsive behaviours related to continence.
The resident's plan of care identified resident mobility and continence needs and strategies related to the responsive behaviour identified.
Strategies for the behaviours were not observed to occur on the identified days. No staff responded to the exhibited behaviour or resident expressed need of care and the resident had to be assisted by an inspector. [s. 6. (7)]

3. The licensee did not ensure the provision of the care set out in the plan of care was documented for multiple residents on identified days when the home did not have full complement of PSWs working.
The home work schedule for PSWs identified that eight PSWs should be scheduled to work each day shift.
On May 22, 2013, the work schedule identified six PSWs working the day shift.
Residents #001, #005, #007, #101, and #102 documentation for provision of care including hygiene, toileting and eating were not completed consistently in the Point of Care (POC) records to indicate care had been provided.
On June 1, 2013, the work schedule identified six PSWs working the day shift.

Residents #001 , #007, and #102 documentation for provision of care including hygiene, toileting and eating were not completed consistently in the Point of Care (POC) records to indicate care had been provided.
On June 2, 2013, the schedule identified five PSWs working the day shift. Residents #005, #007, and #102 documentation for provision of care including hygiene, toileting and eating were not completed consistently in the Point of Care (POC) records to indicate care had been provided.
The staff confirmed that when all staff are not in attendance they cannot complete the care of residents as identified in their plans of care including hygiene, toileting, and bathing. [s. 6. (9)]

4. The licensee did not ensure that Resident #002 plan of care was reviewed and revised and the resident's care needs changed for exhibited responsive behaviours.
On June 11, 2013 the inspectors noted a odour emanating from the resident's room into the common hallway where other residents sit. On inspection of the room the inspectors identified the cause of the odour.
Staff confirmed the resident did exhibit responsive behaviour that was the cause of the odour. Review of the resident's progress notes identified multiple incidents of the responsive behaviour. The most current Resident Assessment Protocol (RAPs) for Behaviours identifed the responsive behaviour as occurring.
The resident plan of care did speak to residents other responsive behaviours but not the new behaviour causing odour. [s. 6. (10) (b)]

5. Resident #007 was not reassessed and the plan of care reviewed when the resident care needs changed. The resident had two unwitnessed falls over a two month period. Each fall identified the resident had been incontinent of urine at the time of the incident.
Staff confirmed the resident had ongoing responsive behaviour related to continence. The most current quarterly assessment for falls, and the current plan of care did not identify incontinence and the responsive behaviour as a trigger for risk of falls. [s. 6. (10) (b)]

6. Resident #003 was not reassessed and the plan of care reviewed and revised when the resident's care needs changed.
The resident was observed as having an acute change in medical status on an identified date in 2013. The resident was assessed by a registered staff. The PSWs confirmed there were no changes provided by the registered staff in the resident's

plan of care due to acute change in physical status. Documentation identified the resident was placed in a wheelchair (not previously utilized) and taken to the dining room after the acute change in status. The documented records did not indicate that any further assessment was completed related to mobility and eating requirements after the resident was initially examined. Staff confirmed there was no instructions provided related to monitoring of the resident's eating and mobility needs related to the physical change in status. [s. 6. (10) (b)]

7. Resident #001 did not have their plan of care revised when the resident's care needs changed. The resident was identified with multiple incidents of altered skin integrity over a 3 month period in 2013.
The issue of the ongoing skin breakdown found on the resident was expressed to the home.
In the response letter by the home to the person expressing the issue it identified a new strategy for staff when providing care to the resident to reduce risk of skin breakdown that could be caused by staff. The resident's plan of care reviewed did not include the identified strategy to minimize skin breakdown. [s. 6. (10) (b)]

8. Resident #004 was not reassessed and the plan of care reviewed when the resident's care needs changed.
Review of the resident's progress notes identified the resident had new symptoms in 2013 and a note was left for the physician to assess. The resident's Medication Administration Records (MARs) identified the resident commenced receiving medication as required for new symptoms.
The resident continued to exhibit new symptoms for 19 days but the plan of care was not revised related to the resident's identified change in medication requirements and care provision.[s. 6. (10) (b)]

9. Resident #007 was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective. The resident had exhibited responsive behaviour related to continence.
The staff confirmed this behaviour was ongoing and strategies were identified.
The plan of care was not revised to reflect the current need for toileting intervals and the responsive behaviour related to continence. [s. 6. (10) (c)]

10. Resident #005 was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not

effective. The resident had exhibited responsive behaviour related to continence. Staff confirmed that the responsive behaviour was ongoing and there were identified strategies. The most current RAPs for April, 2013 did not identify the responsive behaviour. The current plan of care was not revised to reflect the current need for toileting and the responsive behaviour. [s. 6. (10) (c)]

Additional Required Actions:

CO # - 002 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 to ensure residents' Substitute Decision-maker are given opportunity to participate fully in the development and implementation of the resident's plan of care; the care set out in the plan of care is provided to the resident as specified in the plan; the provision of care set out in the plan of care is documented; and when a resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan of care has not been effective., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. The infection prevention and control program must include various practices to control the transmission of infections, one of which is cleaning and disinfection of communal equipment and personal care articles. The home has established procedures (IPC-C-10) for cleaning and disinfecting non-critical reusable personal care equipment, however staff are not following the procedures and management staff are not monitoring the practices of staff. Staff are required to use the soiled utility rooms and to submerge and soak the articles with disinfectant (sink or hopper not specified) after each use. Both of the utility rooms were observed to contain brushes and disinfectant.
Visibly soiled bed pans, wash basins, urinals and/or kidney basins were noted in seven resident rooms on June 10, 2013. When the same items were checked on June 13, 2013, the same fecal stains, urine stains, water scale marks and other unidentified stains were visible. Failure to clean and disinfect personal care articles between use may lead to wound & eye infections, skin irritations and the transmission of organisms such as Methecillin-resistant Staphylococcus Aureus (MRSA) between residents. According to the Assistant Director of Care, the personal articles are to be cleaned and disinfected the night before the resident's bath or shower day. The task has been incorporated into health care worker duties and workers are to use an electronic data system to enter the task as completed. When the bath schedule and the cleaning task was reviewed for residents in three rooms none had their articles cleaned (as observed) or documented as cleaned between June 10 and 14, 2013. According to several staff members, who reported being short-staffed over the course of the last 2 months, cleaning tasks cannot always be completed in order to help residents with activities of daily living such as bathing, toileting, grooming and assistance with eating. [s. 86. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

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Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure the staffing plan provided for a staff mix that was consistent with residents' assessed care and safety needs or include a back-up for nursing and personal care staffing that addressed situations when staff could not come to work.
The home decreased hours for nursing staff by 205.5 biweekly in April 2013 that included RPN and PSW hours.
A) Review of nursing staff schedule for May 2013 identified that the home was short 118.5 PSW hours and 32 RPN hours, and from June 1 to 13, 2013, 80 PSW hours and 11 RN hours, due to non replacement of staff for identified absences.
B) The home had eight PSWs scheduled to work the day shift from 0645 to 1445 hours (day shift). On May 22, 2013 the home had six PSWs working this shift. The resident documentation on Point of Care (POC) identified not all residents received their scheduled baths and therefore did not have a bath till the next scheduled day. All resident identified were scheduled for two baths per week. The residents also did not receive required hygiene care including morning oral care.
C) On June 1, 2013 six PSWs were scheduled for the day shift and on June 2, 2013 five PSWs were scheduled for day shift. Review of POC documentation indicated seven residents received baths out of 13 scheduled on June 1st and five residents received baths out of 14 scheduled on June 2nd. Documentation also identified residents did not receive hygiene care, oral care, toileting assistance during the day shift for June 1st and 2nd.
Staff confirmed that when there is not the full quota of staff working they are unable to complete all aspects of resident care needs including bathing, hygiene and toileting as required in individual plans of care.
D) On June 13, 2013, during the inspection period, the day shift was short two PSWs and the restorative care staff. Review of POC documentation indicated 10 of 14 residents received baths and residents did not have consistent documentation to indicate other care provisions were provided such as oral care, dressing, and toileting.
Observation in the dining room during the lunch meal on this date identified no other staff, including the registered staff, assisted residents with their meals. Residents #006, #0014,and #0022 were observed to not receive assistance required to complete their lunch meal and had to wait extended periods for assistance with meal courses placed in front of them prior to assistance being available. Residents #003, #006, #0014, #0019, #0022, and #0024 did not have their meal served course by course and were observed to have all three courses of their meal in front of them (soup, entree, desert) at one time.
The registered staff stated there was no back up plan for them to follow when they do

not have all staff in attendance and were not able to articulate any change in work routines except for the HCAs in attendance to care for additional residents.
The ADOC confirmed that there was no back up plan in the home when nursing and personal care staff cannot come to work
The Administrator confirmed there was not a back up plan in place for staff to follow when not all staff are in attendance on the dates identified. [s. 31. (3)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

Findings/Faits saillants :

1. Resident #007 was identified as having a responsive behaviour related to continence. Staff stated the resident exhibited this behaviour at least two times per week. Staff were able to identify triggers and strategies to minimize behaviour on some occasions. The resident's most current quarterly assessment dated May, 2013 and plan of care did not identify the responsive behaviour, triggers that may have caused the behaviour or strategies to minimize the behaviour. The BSO consultant confirmed there had been no referral to the BSO team for this resident.
The resident's current plan of care does not include the responsive behaviour related to continence. [s. 53. (2)]

2.Resident #005 was identified as having a responsive behaviour related to continence.
Staff confirmed the resident exhibited this behaviour daily. Staff were able to identify triggers and strategies related to the responsive behaviour.
The resident's most current quarterly RAPs did not identify this responsive behaviour, triggers that may have caused the behaviour or strategies to minimize the behaviour. The BSO consultant confirmed there had been no referral to the BSO team for this resident.
The responsive behaviour was not identified in the resident's plan of care. [s. 53. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of three meals daily. On June 13, 2013, a resident was not offered breakfast.
A) Resident #007 was not offered breakfast on June 13, 2013. Staff indicated that they did not waken the resident and when asked if it was typical to let the resident sleep over breakfast, staff replied that they didn't wake the resident as they were short staffed so made the decision to leave the resident in bed. Staff indicated that they knew the resident would be OK, that the resident eats a good lunch, sometimes double portions. The plan of care for the resident indicated that the resident was at moderate nutritional risk and was diabetic. It did not indicate that staff were not to offer breakfast.
B) Resident #017 was not offered breakfast on June 13, 2013. Staff indicated that the resident did not have breakfast, that this was typical and that they provide the resident with a snack at 10:00 hrs. Staff indicated that on this day, they got the resident up at approximately 1120am and gave the resident a beverage but no snack.
Documentation in POC did not indicate that the resident refused breakfast and the resident's plan of care indicated that the resident was at moderate nutritional risk and requred nutritional supplementation to prevent further weight loss. It did not indicate that staff were not to offer breakfast. [s. 71. (3) (a)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

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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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The resident's meal was not served course by course for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
On June 13, 2013 it had been identified there were 3 staff short in the dining to assist with meals. The lunch meal was observed.
A) Residents #006, #0013, #0014, #0019, #0022, and #0024 were observed to have their entrees served at their place setting while the soup course was still remaining, with residents either not initiating or still consuming the soup.
Residents plans of care did not indicate the residents were assessed as having all courses served at the same time.
B) At 1230 hours desserts were served to multiple tables while the soup and entree courses were still at residents settings and not yet completed. [s. 73. (1) 8.]

2. Residents were not provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
A) Resident #0010 was not provided assistance or encouragement. During the observed lunch meal in the dining room on June 10, 2013, food was on the table in front of resident #0010 at 12:21 hrs. The resident was not provided assistance in eating until 12:30 hours when the Registered Dietitian (RD) came to try to feed the resident. The resident was drinking but refusing solids. The RD left table at 12:32 hours to go to another table, returned awhile later to attempt fluids but the resident refused. There were no further attempts to get the resident to consume solids or fluids and the resident did not consume anything other than a few sips of fluids during the entire meal.
The following day, on June 11, 2013, food was observed in front of the resident and staff attempted to assist the resident at 12:20 hrs, however, the resident did not wake. No further attempts were made to assist or encourage the resident throughout the meal and the resident was removed from the dining room at 12:54 hrs, not having consumed any solids or fluids.
On June 13, 2013, during the lunch meal, food was in front of the resident from 12:35 hrs until 12:55 hrs without assistance being provided. Staff woke the resident at 12:50 hrs, gave the resident a sip of fluid and then the resident went back to sleep. No further encouragement/assistance was provided and the resident did not eat or drink anything other than a sip of a beverage during the meal.
The plan of care for this resident indicated that the resident was at high nutritional risk and required extensive assistance with eating. [s. 73. (1) 9.]

3. Residents #006, and #0022 were not provided with personal assistance and

encouragement required to safely eat and drink as comfortably and independently as possible on June 13, 2013 at the lunch meal.
A) Resident #006 plan of care stated resident required assistance to maintain function to maximum self sufficiency for eating with support provided for set up, encouragement for resident to eat slowly, assistance when eating when showing signs of fatigue.
On June 13, 2013 the resident was observed during the lunch meal. At 1222 hours the resident was served their textured modified entree while the soup remained in front of them and eating had not initiated. The resident was observed to pour all their liquid into the soup and then their entree into the soup. The resident only ate enough soup to have room to add further entree items. The resident was observed from 1215 hours until 1230 hours and their was no action taken as a result of the resident's behaviour of food mixing, or staff encouragement provided to consume the food.
B) Resident #0022 plan of care stated required assistance for eating. with supervision and/or cuing at times. On June 13, 2013 the resident was observed during the lunch meal. At 1215 hours soup was at their setting but not yet consumed and the entree was served. At 1220 hours verbal encouragement was provided once. At 1222 hours the resident commenced to eat a sandwich without consuming any of the soup. At 1230 hours 1 bite of the sandwich was taken and one quarter of the soup consumed. There was no further encouragement or cuing provided. [s. 73. (1) 9.]

4. Residents who required assistance with eating or drinking were not served their meal when someone was available to provide the assistance. Residents who required assistance with eating waited 7-34 minutes with food in front of them before receiving assistance during the inspection.
a) During the observed lunch meal in the dining room on June 10, 2013, food was on the table in front of resident #0010 at 12:21 hours. Assistance in eating was not provided to the resident until 12:30 hours. On June 11, 2012, during the lunch meal, food was in front of the resident from 12:20 hours until 1254 hours without any assistance provided. The resident did not consume anything for lunch and was removed from the dining room at that time. On June 13, 2013, during the lunch meal, food was in front of the resident from 12:35 hours until 12:55 hours without assistance being provided. The resident did not consume any solids or fluids during the lunch meal. The plan of care for this resident indicated that the resident was at high nutritional risk and required extensive assistance with eating.

b) During the observed lunch meal in the dining room on June 10, 2013, food was in

front of resident #009 at 12:26 hrs. Assistance in eating was not provided to the resident until 12:32 hrs. On June 11, 2013, food was in front of the resident from 12:20 hrs until 12:32 hrs without any assistance or encouragement being provided. During the dinner meal, food was brought to table at 17:41 hrs but assistance was not provided to the resident until 17:52 hrs. The plan of care for this resident indicated that the resident was at high nutritional risk and was totally dependent on others for eating. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 007, 008 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 to ensure the home has a dining and snack service that includes at minimum course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee did not ensure the home's Director of Nursing and Personal Care worked regularly in the position on site at the home for at least 35 hours per week.
The home has been without a DOC three times since October 2012.
The home informed the Director that the DOC of the home resigned on July 25, 2013.
In response to the Director's request the home submitted a staff plan for coverage of the DOC role for August 2013. The schedule identified four RNs employed by the home were providing coverage for the DOC position on various days throughout the time frame. The schedule identified the RN fulfilling the role was only on site in the home for two days of the 31.
The Administrator of the home corrected the original submitted schedule to identify there were a total of six days with coverage in the home. The Administrator confirmed that on the remaining 25 days the identified RN was not on site but on-call from outside the home. The ADOC, who has a classification of RPN, would be supervising the nursing department on site and a RN was on site at all times.
The home has not ensured a RN assigned to the role of Director of Care was on site at the home for at least 35 hours per week. [s. 213. (1)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: 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 a policy was implemented in accordance with all applicable requirements under the Act.
The home policy (Long Term Care) LTC-G-160 Nutritional Assessment and Care indicated that all residents will be monitored during the consumption of food and fluids utilizing LTC-G-110 – pleasurable dining policy. As confirmed by the ADOC this policy was pending at the time of the inspection and therefore, not available. [s. 8. (1) (a)]

2. The licensee failed to ensure that policy LTC-G-30-ON Food and Fluid Intake Monitoring was complied with. The policy indicated that all resident's food and fluid consumption per shift shall be documented in POC.
The intake records on Point of Care computer system for resident #010 indicated "response not required" 11 times over 10 days in June, 2013. The DOC confirmed although the program allows for this statement staff were instructed not use it when recording in the POC. On June 10, 2013, staff recorded the resident's intake as 26 to 50% however, the resident was observed by the inspector not to have eaten anything during the lunch meal. On June 11, 2013 the resident also was observed by the inspector not to have eaten anything during the lunch meal, but documentation indicated that the resident had consumed 75-100% of the meal. [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 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, to be implemented voluntarily.

WN #10: 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 did not ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present on June 3, and 5, 2013. On June 3, 2013 there was no RN on duty from 0630 to 1140 hours and on June 5, 2013 there was no RN on duty from 0745 to 1430 hours. Review of the RN schedules identified shortages in RN hours due to vacation taken by the full time staff on both days. The ADOC confirmed there was no RN on duty. She stated she was the person on site but holds a RPN license only [s. 8. (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 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 int he regulations, to be implemented voluntarily.

WN #11: 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 of the long-term care home has not ensured 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.

Four resident washrooms were observed to be equipped with a resident-staff communication and response system, however the cord attached to the receptacle could not activate the system when tested on June 11 & 12, 2013. The receptacle in these washrooms was located to the side of the toilet tank, as opposed to the side as observed in all of the other resident washrooms. In order for the cord to be reached, the home maintenance staff had threaded the cord through eye hooks attached to the walls behind the toilet to bring the cording around from behind the toilet to the side of the toilet. The length of the cord and the 90 degree angle of the cord could not activate the station and therefor was not easily used by the residents or staff.

The above issue was previously identified with the Executive Director in March 2013 who responded by stating that the specific receptacles would be relocated. A written notification was issued at the time. [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 to staff communication response system that can be easily seen, accessed and used by residents. staff and visitors at all times, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plans of care for each resident did not include an assessment to identify the resident's individual sleep patterns or preferences. Residents #007, #0016, #0017, #0018, #0019, and #0020 written plans of care did not include resident's individual sleep preferences or patterns and all were observed in bed with pyjamas on between 1000 and 1030 hours on June 13, 2013. [s. 26. (3) 21.]

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 each plan of care is based on, at a minimum, interdisciplinary assessment of sleep patterns and preferences, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Resident #005 did not have consistent documentation related to interventions for bladder continence. The resident's current plan of care stated the resident was to be toileted in the morning, evening and before and after meals. The documentation in the Point of Care (POC) for the resident related to toileting for seven days in June, 2013 identified the resident was toileted:
three times on three days (once per shift)
two times on two days
four times on one day
no documentation on one day.
Documentation identified resident refused to be toileted once on two days.
The resident was identified as having some recognition of bladder control and a responsive behaviour related to continence. [s. 30. (2)]

2. Resident #007 did not have consistent documentation related to interventions for bladder continence. The resident's current plan of care stated the resident was to be toileted before and after meals and at bed time. The documentation in the Point of Care (POC) for the resident related to toileting for five days identified the resident was toileted:
three times on three days (once per shift)
two times on one day (no toileting documented on day shift)
There was no documentation the resident refused to be toileted. The resident was identified as having some recognition of bladder control. [s. 30. (2)]

3. Resident #001 did not have all actions or interventions for incontinence documented as per the resident plan of care directions. The residents plan of care indicated the resident should have their incontinence product changed a minimum of seven times each 24 hours. The POC guidelines stated documentation should occur when the activity occurs.
Review of the Point of Care (POC) documentation for 21 days identified resident incontinent product was changed from two to five times each 24 hours.
The Administrator confirmed that documentation should occur at the time of an activity but staff have not consistently completed documentation as required. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to the intervention are documented, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that each resident of the home was assisted with getting dressed as required and was dressed appropriately, suitable to the time of the day and in keeping with his or her preferences,in his or her own clean clothing and in appropriate clean footwear. On June 13, 2013 at approximately 10:30 hrs, five residents were found to be still in their pyjamas.

a) Resident #016 was dressed in a housecoat between 10:00-10:30 hrs on June 13, 2013. Staff indicated that the resident was going to have a bath, however, according to the weekly bath list, and documentation in POC,the resident was not provided with a bath on this day. The plan of care for this resident indicated that the resident was totally dependent for dressing and did not indicate any behavioural refusals or preference to stay in pyjamas on bath day. Documentation in POC on June 13, 2013 did not indicate that the resident refused to be dressed. It was documented on June 13, 2013 in POC at 13:35 hrs that the resident was dressed.
b) Resident #017 was found to be dressed in pyjamas between 10:00-10:30 hrs on June 13, 2013 . Documentation in POC on June 13, 2013 did not indicate that the resident refused to be dressed. The plan of care for this resident indicated that the resident required extensive assistance in dressing and did not indicate any behavioural refusals or preference to stay in pyjamas. It was documented on June 13, 2013 in POC at 11:23 hrs that the resident was dressed.
c) Resident #018 was found to be dressed in pyjamas between 10:00-10:30 hrs on June 13,
2013. Documentation in POC on June 13, 2013 did not indicate that the resident refused to be dressed. The plan of care for this resident indicated that the resident required assistance with dressing and did not indicate any behavioural refusals or preference to stay in pyjamas. It was documented on June 13, 2013 in POC at 11:24 hrs that the resident was dressed.
d) Resident #019 was found to be dressed in pyjamas between 10:00-10:30 hrs on June 13, 2013. Staff indicated that the resident was in pyjamas for a bath that day, however, according to the weekly bath list, the resident was not provided a bath on this day. Documentation in POC on June 13, 2013 did not indicate that the resident received a bath or refused to be dressed. The plan of care for this resident indicated that the resident required extensive assistance with dressing and did not indicate any behavioural refusals or preference to stay in pyjamas. It was not documented on June 13, 2013
in POC that the resident was dressed.
e) Resident #007 was found to be dressed in pyjamas between 10:00-10:30 hrs on

June 13, 2013. The plan of care for this resident indicated that the resident required assistance with dressing and did not indicate a preference to stay in pyjamas. The plan of care indicated that if the resident refuses care, staff were to leave and re-approach at a later time, however, documentation in POC and progress notes on June 13, 2013 did not indicate that the resident refused to be dressed. It was not documented on June 13, 2013 in POC that the resident was dressed. [s. 40.]

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 each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his own clean clothing, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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1. Resident #001 did not receive consistent assessment for altered skin integrity by a registered nursing staff using a clinically appropriate assessment instrument.
The resident progress notes identified staff were informed there was new skin breakdown on the resident on three occasions over a five month period. There was no documentation to indicate the altered skin integrity was assessed for these incidents or evidence of them being assessed using a clinically appropriate assessment instrument. The homes policy and procedure stated all residents exhibiting altered skin integrity will be assessed by the nurse and reassessed a minimum of weekly. The Administrator confirmed any altered skin integrity should have an assessment completed. [s. 50. (2) (b) (i)]

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 each resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff , using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 84. Every licensee of a long-term care home shall develop and implement a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents of the long-term care home. 2007, c. 8, s. 84.

Findings/Faits saillants :

1. The licensee did not implement a quality improvement and utilization review system that monitored, analyzed, evaluated and improved the quality of the accommodation, care, services, programs and goods provided to the residents after the home's Risk Quality Improvement (RQI) survey was completed.

The report for the RQI survey was presented to the home on March 15, 2013. This identified inspection, as well as Inspection H-000290-13 for Follow up of previous order from the RQI survey and Inspection #H-000314-13 and H-000344-13 related to critical incidents were initiated on June 10, 2013.

Fifteen non-compliance issued at the RQI survey (1 Order - Compliance Date March 18, 2013, 8 Voluntary Plans of Corrective Action, 6 Written Notices) have been reissued during the above current inspections. The Administrator confirmed action plans have been developed but did not confirm corrective actions in place for all areas. [s. 84.]

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 the home implements a quality improvement and utilization review system that monitors, analyzes, evaluates and improves the quality of the accommodation, care, services, programs and goods provided to residents, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Procedures have not been developed and implemented to address incidents of lingering and offensive odours.

Urine odours were identified upon entry to the home on June 10, 2013 and remained until the inspection was concluded on June 14, 2013. Urine odours were offensive and lingering in an identified corridor of the home, at the end of the corridor in several corners and in two washrooms. Urine odours in the identified corridor were confirmed with staff who reported that several residents urinate outside of their washrooms on a regular basis.
The odours in the two washrooms were offensive before and after the room was cleaned. Stained and odourous urinals with urine residue were observed in both of the washrooms. One washroom was observed to have a large gap between the flooring material and the wall, allowing fluids to enter and seep under the materials. The exhaust units in both washroom were on but had no effect in removing odours. Fecal odours were identified in a resident room on June 11, 2013. Fecal material was observed in the resident's furnishings and reported to registered staff for follow-up. Housekeeping staff were observed cleaning rooms and mopping floors but the urine odours remained a problem in the home. An air cleaner and several mechanical aerosol air spray units were observed in use in the home. The aerosol product masked the odours of the urine but did not help to eliminate odours. Housekeeping staff were observed using a product that was later identified as a Mango scented aerosol to try and cover up urine odours. The combined odour was very offensive. [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. Immediate action is not taken to deal with pests, specifically phorid flies.
Phorid flies (small black flies resembling fruit flies) were observed in various areas of the home (resident washroom, country kitchen and at the main nurse's station) but more specifically in the main kitchen. The flies were observed on walls, ceilings and in numerous quantities on a drainage system located under the soup kettle. The flies typically propagate in dark, wet areas with lots of organic matter available. The home has a contract with a pest management company that visits regularly to help the home manage pests. However, according to the maintenance manager the flies were not identified by the technician during their last several visits and home staff did not report the flies to the technician. As part of the home's program to manage phorid flies, a maintenance person was tasked to clean the drains in the kitchen once per week. Occasionally, the drains would have an insecticidal foam applied to control the fly eggs. Since the maintenance person left the home approximately 2 months ago and has not been replaced, the maintenance manager has not been able to maintain the drains once per week or as necessary. The flies have propagated due to a lack of monitoring, adequate cleaning and removal of organic matter (from a soup kettle drain system, floor drain and the back side of the dishwasher). Immediate action was not taken until the issue was identified during the inspection. [s. 88. (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 immediate action is taken to deal with pests, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that, (c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Procedures have not been developed and implemented to ensure that linens, specifically pillows are kept in a good state of repair. During the inspection on June 10, 11 and 12, 2013, a number of cracked pillows were identified on 12 resident beds. The pillows in four rooms were also identified as cracked during the last visit made on March 1, 2013. [s. 89. (1) (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 linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours, to be implemented voluntarily.

WN #20: 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 home was not safe for residents in an identified room in June, 2013. It was reported to the Ministry and to the home that a resident's a part of a resident's wheelchair was removed and used to hold the bedroom door open. The bedroom doors in the home had self- closing devices on them so that they close automatically should a fire alarm be pulled. In the identified room the magnetic hold open device was not functioning. The maintenance manager was aware of the door and was waiting for a contractor to repair it the same week. The wheelchair part was a trip hazard for workers, visitors and residents. Two out of the three residents in the room were identified at risk of falls and their plans of care required that their environment be maintained free of clutter.

Very loose toilet seats were identified in three resident identified rooms. The maintenance logs kept in the home and accessible to staff did not contain any reports of loose toilet seats. [s. 5.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. Procedures have not been developed and implemented to ensure that all devices, specifically mattresses in the home are kept in good repair.

A mattress in an identified room was observed to be in poor condition on June 12, 2013. The sheets had been removed for laundering and the mattress was exposed. A large portion of the cover for the foam mattress was worn down and peeled back, exposing an absorbent layer. The mattress cover was no longer water resistant and was therefore open to allow any moisture absorbed into the foam and potentially back onto the residents' skin. A mattress in another identified room was also observed to be in poor condition, with a small section peeled back near the head of the bed. [s. 90. (2) (b)]

Issued on this 6th day of November, 2013

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) :	SHARLEE MCNALLY (141), BERNADETTE SUSNIK (120), CAROL POLCZ (156)
Inspection No. / No de l'inspection :	2013_208141_0016
Log No. / Registre no:	H-000287-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 23, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE DONAHUE

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

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

Order # /
Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

Each resident of the home shall have their right fully respected and promoted including their right to be cared for in a manner consistent with his or her needs; their right to privacy in treatment and caring for his or her personal needs; and their right to participate fully in the development, implementation, review and revision of his or her plan of care, and have access to his or her records of personal health.

Grounds / Motifs :

1. Resident #003 was not properly cared for in a manner consistent with his or her needs.
The resident was identified on a specific date to have an acute change in medical status. The registered staff did an initial examination of the resident and confirmed the symptoms. There was no change in the resident's plan of care. The physician was not contacted about the resident's change and the SDM was not contacted for more than two hours. Staff confirmed there was no instructions provided by the registered staff for changing the residents plan of care related to change in medical status. The resident's records did not indicate the registered staff provided direction to PSWs in change of resident care needs or take action in response to change in medical status.
The resident was diagnosed by the hospital with a newly identified medical condition. Contact with the hospital by the home confirmed the resident had a

change in care needs related to the diagnosis. (141)

2. Residents who have received a bath using an identified spa room between June 10 and June 14, 2013 were not afforded the right to privacy. According to staff, the spa room has not had a privacy curtain for many months.
The tub located in the spa room was not equipped with a privacy curtain so that residents could be given complete privacy while bathing and while getting dressed. The door to the tub room when opened, offers a direct line of sight to residents while in the tub or while being dressed. The spa room also has a toilet area and a shower area, which according to staff, is used by other residents while a resident is being bathe. (120)

3. This order was previously issued as a Written Notice for Inspection #2013_105130_0005 issued March 15, 2013.
Residents receiving treatment for diabetes were not afforded privacy for testing of blood sugars on administration of insulin by injection.
A)An Inspector observed in the resident dining room on June 12, 2013, a RN standing with a medication cart. The RN stated the cart was used for blood sugar testing and insulin administration. The RN further stated they were aware that the treatments should be done in privacy but many of the residents bring themselves to the dining room before 1130 hours and the staff cannot get them to wait in their rooms, therefore the staff have no choice but to give the treatments in the dining room in the presence of other residents.
B)On June 12, 2013 an inspector observed while in the dining room during the evening meal:
i) A RN check resident #0012 blood sugar at the table at 1650 hours.
ii) A RN administer injectable insulin to resident #0011 in the dining room.
iii) A RPN was observed administering insulin to residents #013, #014, #102, and #006 in the dining room at their respective tables from 1650 hours to 1710 hour.
C) On June 13, 2013, the RN on the day shift confirmed they had administered the lunch insulins and completed the blood sugar testing. The RN stated they had administered five insulins and seven glucometer testings. The RN identified the following
i) Resident #0011 was administered insulin in the hall in front of other residents. The resident had been instructed to wait in their room but had come down to the hall outside the dining room.
ii) Resident #0013 was administered insulin in the activity room in presence of

other residents. The resident had been in the room to attend a program and their bedroom was too far away and there was too many residents outside in the hall to direct the resident through.
Staff confirmed there were areas near the dining room that could afford privacy for the testing of blood sugars and administration of insulin but privacy had not been respected. [s. 3. (1) 8.] (141)

4. Resident #001 rights were not fully respected and promoted in respect to the revision of their plan of care. The resident's progress notes on an identified date indicated their Power of Attorney (POA) requested to have the resident placed back in bed at specific time of day with specific direction for the bed positioning. On a later identified date, the POA informed to the Administrator they had observed the resident in bed with incorrect positioning. The Administrator responded to the POA's concern in writing acknowledging the POAs request. The resident's current Plan of Care identified the POA's request for the resident to be placed in bed at a specific time but did not provide direction for the bed positioning.
The resident's comfort was not identified and choices respected in provision of care. (141)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2013

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall prepare, implement and submit a plan that ensures that each resident is reassessed and their plan of care reviewed and revised when the resident care needs change or care set out in the plan is not longer necessary, including residents #001, #002 #003, #004, #005, and #007, The plan shall be submitted by September3, 2013 to Long Term Care Inspector Sharlee McNally at: Sharlee.McNally@ontario.ca

Grounds / Motifs :

1. This order was previously issued as a Voluntary Plan of Corrective Action for Inspection #2013_105130_0005 issued March 15, 2013.
Resident #004 was not reassessed and the plan of care reviewed when the resident's care needs changed.
Review of the resident's progress notes identified the resident had new symptoms in 2013, and a note was left for the physician to assess. The resident's Medication Administration Records (MARs) identified the resident commenced receiving medication as required for new symptoms.
The resident continued to exhibit new symptoms for 19 days but the plan of care was not revised related to the resident's identified change in medication requirements and care provisio

(141)

2. Resident #001 did not have their plan of care revised when the resident's care needs changed. The resident was identified with multiple incidents of altered skin integrity over a three month period.
The issue of the ongoing skin breakdown found on the resident was expressed to the home. In the response letter by the home to the person who expressed the issue it identified a new strategy for staff when providing care to the resident to reduce risk of skin breakdown that could be caused by staff. The resident's plan of care reviewed did not include the identified strategy to minimize skin breakdown. (141)

3. Resident #003 was not reassessed and the plan of care reviewed and revised when the resident's care needs changed.
The resident was observed as having an acute change in medical status on an identified date in 2013. The resident was assessed by a registered staff. The PSWs confirmed there were no changes provided by the registered staff in the resident's plan of care due to acute change in physical status. Documentation identified the resident was placed in a wheelchair (not previously utilized) and taken to the dining room after the acute change in status. The documented records did not indicate that any further assessment was completed related to mobility and eating requirements after the resident was initially examined. Staff confirmed there was no instructions provided related to monitoring of the resident's eating and mobility needs related to the physical change in status. (141)

4. Resident #007 was not reassessed and the plan of care reviewed when the resident care needs changed. The resident had two unwitnessed falls over a two month period in 2013. Each fall identified the resident had been incontinent of urine at the time of the incident.
Staff confirmed the resident had ongoing responsive behaviour related to continence. The most current quarterly assessment for falls and the current plan of care did not identify incontinence and the responsive behaviour as a trigger for risk of falls.
(141)

5. The licensee did not ensure that Resident #002 plan of care was reviewed and revised and the resident's care needs changed for exhibited responsive behaviours. On June 11, 2013 the inspectors noted a odour emanating from the resident's room into the common hallway where other residents sit. On

inspection of the room the inspectors identified the cause of the odour.
Staff confirmed the resident did exhibit responsive behaviour that was the cause of the odour. Review of the resident's progress notes identified multiple incidents of the responsive behaviour. The most current Resident Assessment Protocol (RAPs) for Behaviours identifed the responsive behaviour as occurring.
The resident plan of care did speak to residents other responsive behaviours but not the new behaviour causing odour. (141)

6. Resident #005 was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective. The resident had exhibited responsive behaviour related to continence. Staff confirmed that the responsive behaviour was ongoing and there were identified strategies. The most current RAPs did not identify the responsive behaviour. The current plan of care was not revised to reflect the current need for toileting and the responsive behaviour.. (141)

7. Resident #007 was not reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan was not effective. The resident had exhibited responsive behaviour related to continence. The staff confirmed this behaviour was ongoing and strategies were identified.
The plan of care was not revised to reflect the current need for toileting intervals and the responsive behaviour related to continence (141)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 20, 2013

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 : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan summarizing the following:
1. When all care staff were trained on cleaning and handling methods of reusable personal care articles such as bed pans, urinals and wash basins and who provided the training.
2. Who audits reusable personal care articles and how often for cleanliness and condition.
3. Who audits and how often, staff practices related to adequate cleaning and disinfection of reusable personal care articles.
4. Submit a copy of the homes customized procedure on the steps staff are to follow on the handling of a bed pan, wash basin and urinal after residents use them. The procedure shall outline how staff are to use the available sink in the soiled utility rooms, how the disinfection chemicals are to be used, how articles will be washed/disinfected, dried, stored and re-distributed.
The plan shall be submitted to Bernadette Susnik, LTC Homes Inspector, either by mail or email to 119 King St. E., 11th Floor, Hamilton, ON, L8P 4Y7 or Bernadette.susnik@ontario.ca by August 30, 2013, 2013.

Grounds / Motifs :

1. This order was previously issued as a Voluntary Plan of Corrective Action for Inspection #2013_105130_0005 issued March 15, 2013.
The infection prevention and control program must include various practices to control the transmission of infections, one of which is cleaning and disinfection of communal equipment and personal care articles. The home has established procedures (IPC-C-10) for cleaning and disinfecting non-critical reusable personal care equipment, however staff are not following the procedures and management staff are not monitoring the practices of staff. Staff are required to use the soiled utility rooms and to submerge and soak the articles with disinfectant (sink or hopper not specified) after each use. Both of the utility rooms were observed to contain brushes and disinfectant.
Visibly soiled bed pans, wash basins, urinals and/or kidney basins were noted in seven identified resident rooms on June 10, 2013. When the same items were checked on June 13, 2013, the same fecal stains, urine stains, water scale marks and other unidentified stains were visible. Failure to clean and disinfect personal care articles between use may lead to wound & eye infections, skin irritations and the transmission of organisms such as Methecillin-resistant Staphylococcus Aureus (MRSA) between residents.
According to the Assistant Director of Care, the personal articles are to be cleaned and disinfected the night before the resident's bath or shower day. The task has been incorporated into health care worker duties and workers are to use an electronic data system to enter the task as completed. When the bath schedule and the cleaning task was reviewed for residents in three identified rooms none had their articles cleaned (as observed) or documented as cleaned between June 10 and 14, 2013. According to several staff members, who reported being short-staffed over the course of the last 2 months, cleaning tasks cannot always be completed in order to help residents with activities of daily living such as bathing, toileting, grooming and assistance with eating.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee shall prepare, implement and submit a plan that ensures the staff plan for nursing staff provides for a staffing mix that is consistent with the residents' assessed care needs, and includes a back-up plan plan of nursing and personal care staffing thatt addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8(3) of the Act. The plan shall be submitted by August 30, 2013 to Long Term Care Inspector Sharlee McNally at: Sharlee.McNally@ontario.ca

Grounds / Motifs :

1. The licensee did not ensure the staffing plan provided for a staff mix that was consistent with residents' assessed care and safety needs or include a back-up for nursing and personal care staffing that addressed situations when staff could not come to work.
The home decreased hours for nursing staff by 205.5 biweekly in April 2013 that included RPN and PSW hours.
A) Review of nursing staff schedule for May 2013 identified that the home was