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
May 2, 2014	2014_240506_0009	H-000320-14/H-000321-14	Follow up

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

LESLEY EDWARDS (506), CAROL POLCZ (156), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 1,2,3,4,8,9,10,12,14 and 15, 2014

This follow-up inspection was conducted simultaneously with a complaint inspection #2014_240506_0010/H-000245-14/H-000360-14. Areas of non compliance related to the compliant inspection for s.6(7), s.6(10), s.31(3)(a) will be issued on this follow-up report. were also completed by inspector #130 including s.6(10)b. s.6(7),s.6(10)(b),s.31(3)(a) will also be issued in this inspection report. Areas of non compliance were also completed by inspector #130 including s.6(10)b.

During the course of the inspection, the inspector(s) spoke with Executive Director(ED), Director of Care(DOC), Associate Director of Care(ADOC), Corporate Staff, Registered Staff, Food Service Manager(FSM), Dietician, Program Manager, Restorative Care Aide, Personal Support Workers (PSW),dietary staff, activation staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed care and services,interviewed staff, residents and families, reviewed clinical records, business files and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Dining Observation
Food Quality
Medication
Nutrition and Hydration
Pain
Personal Support Services
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. Previously issued as a CO on December 2013.

The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours.

The shortfall was identified based on provision of 3 meals per day for 79 Long Term Care Home residents, 66 Retirement Home residents and 10 apartment meals/day. Staff for the Long Term Care Home prepare, distribute, clean and receive for the Retirement Home meal services. Based on the calculation,
M total = [Ax7x0.45] + [(B/3) x 0.45] + (C/3) x 0.22]
M = total hours /week
A = occupancy of home = 79
B = number of meals prepared for RH = 66x7 days/week x 3 meals/day = 1386
C = number of meals prepared for non residents = 10 apartment residents/day x 7 days/week = 70
Therefore, M = [79x7x0.45] + [(1386/3) x 0.45] + [(70/3) x 0.22]
= 248.9 + 208 + 5.1
= 462 hours/week
And therefore, 462/7 = 66 hours/day
The required minimum staffing hours for food service workers was calculated to be 66 hours per day or 462 hours per week. As confirmed by the Administrator, the home was providing 63.5 hours per day, therefore, the home was short 2.5 hours per day or 17.5 hours per week of food service worker hours. [s. 77. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

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. Previously issued as a CO on August 2013.

The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs with regards to residents receiving assistance with meals, receiving baths and attendance to resident call bells.

It was noted that the job routines for dietary and PSW staff had recently changed from dietary staff plating the food and bringing the plates to the tables to dietary staff plating the food and PSW staff now bringing the plates to the tables. As a result, the front line staff indicated that residents needed to wait to be served because there was no one to assist them as they were now serving the food. The length of time for residents to receive their meals and/or assistance was found to be excessive because there was not enough staff available to assist.

A) On an identified date in April, 2014, Inspectors #536 and #585 observed the lunch meal to begin at 12:00 hours and noted that it was lengthy and was still ongoing after 13:00 hours. Later that day, Inspectors #506, #536 and #585 observed residents in the dining room at 17:00 hours when dinner was to start, however the dinner meal did not start until 17:20 hours. Residents were observed still being fed at 18:40 hours.

Residents #095, #099 and #095 were observed leaving the dining room as it was very loud and they had been sitting and waiting too long to be served. The Lodge Director was present to observe the meal and confirmed that people were leaving because they had been sitting and waiting too long. The residents were redirected back to their tables and eventually did consume their meal. Some residents were observed not getting their dinner until 18:00 hours.
B) On an identified date in April, 2014 the FSM confirmed to Inspector #585 that the meal service was taking longer since the change of assignment from dietary staff to PSWS serving the tables.
C) On an identified date in April, 2014 a PSW was overheard by Inspector #506 stating "this is ridiculous, I thought residents were supposed to get their meals faster than this with the new changes" and another uttered "this is supposed to be pleasurable?" while referring to the length of time for service.
D) During the meal observed on an identified date in April, 2014 at a table, resident #024 was noted on the plan of care to require extensive assistance and the table mate, resident #025 was noted on the plan of care to be totally dependent on others for feeding. Both of these residents were sitting with two others who had food at approximately 12:00 hours, however, resident #024 was not provided the meal until 12:45 hours. Resident #025 did not receive the meal until 12:55 hours.
E) Resident #007 was noted on the plan of care to require total assistance and verbal cuing to chew and swallow. Resident #023 was noted on the plan of care to require total feeding assistance. Neither of the residents received their meals until 12:55 hours. Several residents had left the dining room and several others including the table mates had already eaten dessert.
F) On an identified date in April, 2014 two family members were overheard making comments that there are never this many staff helping in the dining room, and a staff mentioned 'this is supposed to be pleasurable?"

2.Staff were observed complaining that residents had to wait for assistance.

A) Resident #003 was observed to receive their meal at lunch on an identified date in April, 2014 at 1210 hours, however, the resident was not provided assistance until 1245 hours because there was no staff available to asssit.
B) Resident #001 was observed to receive hot cereal at breakfast on an identified date in April, 2014 at 0835 hours. The resident was not feeding himself and was not offered any assistance until 0905 hours until there was someone available to assist.
C) Resident # 012 was observed to receive hot cereal at breakfast on an identified date in April, 2014 at 0850 hours. The resident was not offered assistance until 0920

hours.
D) On an identified date in April, 2014, resident #094 had a plan of care to receive extensive to total assistance to eat meals. The resident was observed to receive their entree at 12:45 hours. The resident was not offered assistance until 13:15 hours as observed by Inspector #585.

3.Residents were not provided with a bath on an identified date in April, 2014 due to there not being enough staff for this provision as the home was short PSW staff. Inspector #506 verified with the PSW that the home was short two PSW staff on this day. Only one bath out of 12 was completed for the day. There were no alternatives made to replace the missed baths as the management staff were not aware the baths were not completed on an identified date in April, 2014.

4.On an identified date in April, 2014, at approximately 0930 hours, resident #021 pushed the call bell as they needed assistance with their activities of daily living. When the Inspector informed the staff that the resident was still waiting for assistance after half an hour, the staff member acknowledged that the call bell was ringing and stated that she was by herself and could not go down there and leave another resident unattended. The resident waited for assistance for an hour because there was not a staff member available to assist because the home was short a PSW staff on this day. [s. 31. (3) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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. Previously issued as a CO on November 2013 and March 2014.

The Licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their plans.

A) Resident #008 was observed on an identified date in April, 2014 during the noon meal with specialized equipment in place, however the specialized equipment was not turned on. The resident's plan of care directs staff to ensure resident is using the specialized equipment at all times.
B) Resident #009 was observed on an identified date in April, 2014 during the noon meal with specialized equipment in place, however the specialized equipment was not turned on and when the Registered staff turned the specialized equipment on the battery was drained. The plan of care directs staff to ensure resident is using the specialized equipment at all times.
C) The inspector observed resident #008 on an identified date in April, 2014 at 1400 with the ADOC and the resident had their specialized equipment in place but the specialized equipment was not turned on.
D) Resident #010 plan of care directs staff to ensure resident is using their specialized equipment at all times. Observation of resident #010 at 1515 on an identified date in April, 2014 in the hall confirmed that resident had their specialized equipment in place, however the machine was turned off. The staff member came over and confirmed that the specialized equipment was not turned on.
E) During an observation on an identified date in April, 2014 of resident #008,the inspector noted resident had been receiving specialized equipment at a required amount. The physician's order indicated that the dose the resident should be receiving

was at a different. The ADOC confirmed with the inspector that the incorrect dose was being administered to the resident. [s. 6. (7)]

2. Resident #007 plan of care directed staff to put resident back to bed everyday after lunch and get up at 1630 hours daily. The resident was noted to be seated at the nurses station all afternoon sleeping on an identified dates in April,2014. The ADOC confirmed that resident should have been put to bed as per the plan of care. [s. 6. (7)]

3. The plan of care for resident #300 indicated that resident had a prescribed snack at morning nourishment pass. The nourishment pass was observed on an identified date in April, 2014 and these items were not provided to the resident. The resident confirmed this as well. The PSW who completed the nourishment pass confirmed that these items were not provided.
A)The plan of care for resident #100 indicated that a prescribed snack was to be provided to the resident at the morning nourishment pass. During the observed nourishment pass on an identified date in April, 2014, the snack was not provided to the resident or available on the nourishment cart. The plan of care for this resident also indicated that the resident was to be provided with chocolate milk at lunch. During the observed meal on an identified date in April, chocolate milk was not provided to resident.
B)The plan of care for resident #301 indicated that an adaptive device was to be provided at meals. During the observed meal on an identified date in April, 2014, the adaptive device was not provided to the resident as specified in the plan. [s. 6. (7)]

4. During an observation on an identified date in April, 2014 noon meal resident #011 was given a regular textured meal. A review of residents plan of care confirmed that the resident was to have a minced textured meal. The ED confirmed that the resident was given the wrong texture. [s. 6. (7)]

5. The plan of care for resident #005 confirmed that the resident was to have a specimen collected every two months since August 2013. There was no documentation on the resident's health record to confirm that the specimen was obtained or sent to the laboratory from August 2013 until February 2014. The RN confirmed that a specimen was not taken during this time frame. [s. 6. (7)]

6. During the observed meal on an identified date in April, 2014, resident #001 was sitting at the table with fluids in front of the resident. The juices were noted to be thickened, however, the coffee and milk did not appear to be thickened. It was noted

that the resident was to receive nectar consistency fluids according to the serving notes and the resident's plan of care. The inspector brought this to the attention of staff, who confirmed that it was not at the proper consistency and then added more thickener to thicken it to nectar consistency.
On an identified date in April, 2014, during the observed meal, a dietary aide was observed thickening a glass of milk without using a measuring spoon to ensure proper consistency. The FSM confirmed that staff should be using a measuring spoon and brought one out for the dietary aide to use to achieve proper consistency.
On an identified date in April, 2014, during the observed meal, a dietary aide thickened tea and coffee using a teaspoon and not measuring spoon. The inspector confirmed with dietary aide that the wrong spoon was used. The FSM confirmed on a previous observed day that the staff were to use a measuring spoon to thicken fluids.
On an identified date in April, 2014 resident #097 was noted on the serving notes to receive mashed potatoes at lunch and dinner however this was not provided during the observed lunch meal. [s. 6. (7)]

7. Resident #011 on an identified date in April, 2014 was observed by inspector #585 at the breakfast meal to have been served a glass of white milk that was partially consumed. Inspector was aware from reviewing residents plan of care that it indicated resident had an allergy to milk. The inspector confirmed that the milk was served to this resident by the dietary aide and confirmed by the dietary aide that they did not reference the plan of care prior to serving the milk or servery notes. [s. 6. (7)]

8. Previously issued as a CO on November 2013 and December 9, 2013

The licensee failed to ensure that residents were reassessed and the plans of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan was no longer necessary.

A) Resident #003 was readmitted to the home from hospital on an identified date in March, 2014, with an identified pressure wound, and using a medical device. The written plan of care did not identify impaired skin integrity and did not identify that that the resident had a medical device. This information was confirmed by staff.

B) Resident #016's plan of care indicated resident was having newly identified pain and was complaining of pain and had been receiving pain medication whenever necessary. The resident was hospitalized and pain was not being controlled and subsequently was put on a new pain medication. Resident #016's plan of care was

not revised to include pain management. The ADOC confirmed that the resident's plan of care should have been reviewed and revised to include pain managment. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 003, 004 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. 73. Dining and snack service

Specifically failed to comply with the following:

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. Previously issued as a CO on August 2013.

The licensee failed to ensure residents who required assistance with eating or drinking were served when someone was available to provide the assistance.

A) Resident #003 was observed to receive a pureed meal on an identified date in April, 2014. The resident was not offered assistance for 35 minutes. The plan of care indicates resident requires total assistance.
B) Resident #001 was observed to receive hot cereal at breakfast on an identified date in April, 2014. It was noted that the resident was not feeding themself and was not offered any assistance for 35 minutes when the PSW proceeded to feed resident their meal. The plan of care indicated the resident requires extensive assistance.
C) Resident #012 was observed to receive hot cereal at breakfast on an identified date in April, 2014. The resident was not offered assistance for 30 minutes. The plan of care indicated the resident requires constant encouragement.
D) On an identified date in April, 2014, resident #094 had a plan of care to receive extensive to total assistance to eat meals. The resident was observed to receive their entree at 12:45 hours. The resident was not offered assistance until 13:15 hours as observed by Inspector #585. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 005 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Previously issued as a CO on December 2013.

The licensee failed to ensure that all drugs were administered to residents as prescribed by the prescriber.

During a review of the home's medication incident reports indicated that residents did not receive their prescribed medications.

A) Resident #021 was to receive their medication one capsule every 12 hours. The registered staff on duty on an identified date in February, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next shift.
B) Resident #010 was to receive their medication one capsule every 12 hours. The registered staff on duty on an identified date in February, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the day shift.
C) Resident #015 was to receive medication daily for seven days. Four doses were left in the vial and consequently the resident had to receive another course of medication for seven days.
D) Resident #041 was to receive their medication one capsule every eight hours. The registered staff on duty on an identified date in February, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift.
E) Resident #042 was to receive 1700 hours scheduled medications on an identified date in March, 2014. The registered staff on duty did not give the medications as prescribed as were found in the strip pack by the nurse on the next day shift.
F) Resident #005 was to receive their medication one capsule every 12 hours. The registered staff on duty on an identified date in March, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift.
G) Resident #043 was to receive their medication half tablet three times a day. The registered staff on duty on an identified date in March, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift.
H) Resident #044 was to receive their pain medication daily. The registered staff on duty on an identified date in March, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift. [s. 131. (2)]

Additional Required Actions:

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

WN #6: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident was properly cared for in a manner consistent with his or her needs.

A) On an identified date in April, 2014 during the observed meal, resident #099 informed the inspector that the tablemate, resident #001 was uncovered The resident indicated that this made them feel very uncomfortable. Discussion occurred with the Administrator who indicated that the resident was to be dressed this way. The Administrator proceeded to cover the resident up and stated that she had covered them up three times during the meal. The plan of care indicated that the resident is to be dressed this way.
B) On an identified date in April, 2014, at approximately 0930 hours, resident #021 was in the hall outside of the room asking for help and looking for assistance. The resident indicated that they needed help with their pants and the inspector instructed them to push their call bell, which they did. It was noted that there was a PSW in the room next door and the Administrator was nearby but there was no acknowledgment to the resident or the call bell 'ringing'. The resident was in and out of the room looking down the hall for assistance and after thirty minutes one of the inspectors went down the hall and informed the registered staff that the resident had been waiting for quite some time. It was another half hour before the call bell light was turned off and the resident received assistance. The resident was not properly cared for in a manner consistent with his needs as he waited for an hour for assistance. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents are properly cared for in a manner consistent with his or her needs, to be implemented voluntarily.

WN #7: 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. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home's policy related to "Documentation/Health Records Interdisciplinary Documentation LTC-D-20, dated August 2012" policy was not followed.
The policy required that a resident record should be factual, internally consistant, concise and accurate, and be written from first-hand knowledge, except in an emergency where one practitioner may be designated as the recorder.
A review of the clinical record for resident #301 indicated that the resident received a supplement. On an identified date in April, 2014, the resident was observed to consume none of the supplement, however according to the electronic medication administration record, the resident consumed all of the supplement. The RPN who documented the resident's intake stated that they relied on a PSW to report back on how much the resident consumed. The RPN confirmed that they were responsible for accurate documentation of the resident's supplement intake and that the documentation was incorrect.
B) During a review of the home's medication incident reports from February to March 2014 there were eight incidents of medications that were not given but were documented as signed off by the registered staff as administered to the residents.
C) During a review of resident #100 flow sheet documentation it stated that resident was not available for all three meals on an identified date in April, 2014. This was not accurate as the resident was in the home but was not offered a meal as observed by the inspector. The ADOC confirmed that the documentation was not accurate. [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 the home policy on documentation are complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were bathed, at a minimum, twice a week.

A review of the home's documentation system indicated only one out of 12 residents received their bath on the day shift. The PSW confirmed that the home was short two PSW staff on this day. There were no alternatives made to replace the missed baths as the management staff were not aware the baths were not completed on an identified date in April, 2014. [s. 33. (1)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident's weight was measured and recorded monthly. A review of the plan of care showed there were no recorded weights for resident #004 and #040 in February and March 2014, and for resident #307 in March 2014. The Registered Dietitian confirmed that these weights were not measured and recorded as the weight scale was broken at the time. [s. 68. (2) (e) (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 that each resident's weight is measured and recorded monthly, to be implemented voluntarily.

WN #10: 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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of three meals daily.

Resident #100 was observed to be sleeping in their bed throughout the day on an identified date in April, 2014. Resident #100 did not attend breakfast, lunch or dinner and tray service was not offered to the resident. The resident's plan of care indicated that the resident was high nutritional. Resident #100 is to be offered a prescribed snack at morning nourishment and the prescibed snack on this day was not offered. It was observed that the resident did not attend lunch, but was provided an afternoon snack. The inspector observed that the resident did not attend the dining room for dinner. Resident came to the nurses station at 1840 when dinner was finishing and no one offered resident a meal. There was no documentation to indicate that resident #100 refused to attend their meals on an identified date in April, 2014, just that resident was unavailable. The ADOC confirmed that the resident should have been offered a tray service for lunch and dinner. [s. 71. (3) (a)]

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

A) On an identified date in April, 2014, regular texture stewed prunes were not offered (as per the planned menu) at the breakfast meal. A Food Service Worker stated that residents only get prunes if they ask for them. The Cook reported regular prunes were to be available and out on counter for service. The Cook identified regular stewed prunes were not on counter for service. Food Service Manager confirmed stewed prunes were available in kitchen to be served and should be available and offered at meals for residents. Residents #100, #307 and #306 confirmed to the inspector that they were not offered prunes at the meal .
B) On an identified date in April, 2013 the supper planned menu identified red potatoes as a choice, however mashed potatoes were served. The cook confirmed red potatoes were not available as the order did not come in. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are offered a minimum of three meals daily and to ensure that planned menu items are offered, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all menu substitutions were communicated to residents and staff.

On an identified date in April, 2014, at dinner, red potatoes were posted on the menu as a second choice meal option. No red potatoes were observed in the dining room. The cook confirmed that there was no red potatoes available and mashed potatoes were offered. The menu board was not changed to reflect the substitution. The FSM confirmed that the menu change was not communicated. [s. 72. (2) (f)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

A) On an identified date April, 2014, during the observed meal service, one staff member was observed removing dirty dessert dishes from the dining room table and continued serving dessert to other residents without washing hands.
B) On an identified date in April, 2014, during the observed meal service, two staff members were observed removing dirty dessert dishes from the dining room table and continued serving dessert to other residents without washing hands.
C) On an identified date in April, 2014, during the nourishment pass, the inspector observed a staff member blow their nose then proceeded to assist the resident to consume the nourishment without washing their hands. [s. 229. (4)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 134.	CO #002	2013_201167_0036	506
O.Reg 79/10 s. 73. (1)	CO #003	2013_201167_0034	156

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

Issued on this 15th day of May, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Sharlee McNally for Lesley Edwards

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) :	LESLEY EDWARDS (506), CAROL POLCZ (156), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2014_240506_0009
Log No. / Registre no:	H-000320-14/H-000321-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 2, 2014
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

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_201167_0034, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks;
(b) the distribution and service of resident meals;
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that there is sufficient food service worker hours to meet the minimum staffing hours. The plan shall include written job routines for all food service worker positions that outline the shift and the time spent on duties for long-term care, retirement home and other meals. The plan should be submitted via email by May 16, 2014 to Carol Polcz at carol.polcz@ontario.ca at the Ministry of Health and Long Term Care, Hamilton, ON

Grounds / Motifs :

1. Previously issued as a CO on December 9, 2013.

The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours.

The required minimum staffing hours for food service workers was 66 hours per day or 462 hours per week. The home was providing 63.5 hours per day or 444.5 hours per week. A shortfall of 2.5 hours per day or 17.5 hours per week of food service worker hours was identified based on the provision of three meals per day for 79 Long Term Care Home residents and 66 Retirement Home residents and 10 apartment meals per day. Staff for the Long Term Care Home prepare, distribute, clean and receive for the Retirement Home meal services. The Administrator confirmed that these hours were correct at the time of the inspection.
(156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 ensure that the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs related to receiving baths, assistance with meals and attendance to resident call bells.

Grounds / Motifs :

1. 1. Previously issued as a CO on August 2013.

The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs with regards to residents receiving assistance with meals, receiving baths and attendance to resident call bells.

It was noted that the job routines for dietary and PSW staff had recently changed from dietary staff plating the food and bringing the plates to the tables to dietary staff plating the food and PSW staff now bringing the plates to the tables. As a result, the front line staff indicated that residents needed to wait to be served because there was no one to assist them as they were now serving the food.

The length of time for residents to receive their meals and/or assistance was found to be excessive because there was not enough staff available to assist.

A) On an identified date in April, 2014, Inspectors #536 and #585 observed the lunch meal to begin at 12:00 hours and noted that it was lengthy and was still ongoing after 13:00 hours. Later that day, Inspectors #506, #536 and #585 observed residents in the dining room at 17:00 hours when dinner was to start, however the dinner meal did not start until 17:20 hours. Residents were observed still being fed at 18:40 hours. Residents #095, #099 and #095 were observed leaving the dining room as it was very loud and they had been sitting and waiting too long to be served. The Lodge Director was present to observe the meal and confirmed that people were leaving because they had been sitting and waiting too long. The residents were redirected back to their tables and eventually did consume their meal. Some residents were observed not getting their dinner until 18:00 hours.
B) On an identified date in April, 2014 the FSM confirmed to Inspector #585 that the meal service was taking longer since the change of assignment from dietary staff to PSWS serving the tables.
C) On an identified date in April, 2014 a PSW was overheard by Inspector #506 stating “this is ridiculous, I thought residents were supposed to get their meals faster than this with the new changes” and another uttered “this is supposed to be pleasurable?” while referring to the length of time for service.
D) During the meal observed on an identified date in April, 2014 at a table, resident #024 was noted on the plan of care to require extensive assistance and the table mate, resident #025 was noted on the plan of care to be totally dependent on others for feeding. Both of these residents were sitting with two others who had food at approximately 12:00 hours, however, resident #024 was not provided the meal until 12:45 hours. Resident #025 did not receive the meal until 12:55 hours.
E) Resident #007 was noted on the plan of care to require total assistance and verbal cuing to chew and swallow. Resident #023 was noted on the plan of care to require total feeding assistance. Neither of the residents received their meals until 12:55 hours. Several residents had left the dining room and several others including the table mates had already eaten dessert.
F) On an identified date in April, 2014 two family members were overheard making comments that there are never this many staff helping in the dining room, and a staff mentioned ‘this is supposed to be pleasurable?”

2.Staff were observed complaining that residents had to wait for assistance.

A) Resident #003 was observed to receive their meal at lunch on an identified date in April, 2014 at 1210 hours, however, the resident was not provided assistance until 1245 hours because there was no staff available to asssit.
B) Resident #001 was observed to receive hot cereal at breakfast on an identified date in April, 2014 at 0835 hours. The resident was not feeding himself and was not offered any assistance until 0905 hours until there was someone available to assist.
C) Resident # 012 was observed to receive hot cereal at breakfast on an identified date in April, 2014 at 0850 hours. The resident was not offered assistance until 0920 hours.
D) On an identified date in April, 2014, resident #094 had a plan of care to receive extensive to total assistance to eat meals. The resident was observed to receive their entree at 12:45 hours. The resident was not offered assistance until 13:15 hours as observed by Inspector #585.

3.Residents were not provided with a bath on an identified date in April, 2014 due to there not being enough staff for this provision as the home was short PSW staff. Inspector #506 verified with the PSW that the home was short two PSW staff on this day. Only one bath out of 12 was completed for the day. There were no alternatives made to replace the missed baths as the management staff were not aware the baths were not completed on an identified date in April, 2014.

4.On an identified date in April, 2014, at approximately 0930 hours, resident #021 pushed the call bell as they needed assistance with their activities of daily living. When the Inspector informed the staff that the resident was still waiting for assistance after half an hour, the staff member acknowledged that the call bell was ringing and stated that she was by herself and could not go down there and leave another resident unattended. The resident waited for assistance for an hour because there was not a staff member available to assist because the home was short a PSW staff on this day. [s. 31. (3) (a)] (156)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_201167_0034, CO #001; 2013_201167_0034, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

1. 1. Previously issued as a CO on November 2013 and March 2014.

The Licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their plans.

A) Resident #008 was observed on an identified date in April, 2014 during the noon meal with specialized equipment in place, however the specialized equipment was not turned on. The resident's plan of care directs staff to ensure resident is using the specialized equipment at all times.
B) Resident #009 was observed on an identified date in April, 2014 during the noon meal with specialized equipment in place, however the specialized equipment was not turned on and when the Registered staff turned the specialized equipment on the battery was drained. The plan of care directs staff to ensure resident is using the specialized equipment at all times.
C) The inspector observed resident #008 on an identified date in April, 2014 at 1400 with the ADOC and the resident had their specialized equipment in place but the specialized equipment was not turned on.
D) Resident #010 plan of care directs staff to ensure resident is using their specialized equipment at all times. Observation of resident #010 at 1515 on an identified date in April, 2014 in the hall confirmed that resident had their specialized equipment in place, however the machine was turned off. The staff

member came over and confirmed that the specialized equipment was not turned on.
E) During an observation on an identified date in April, 2014 of resident #008,the inspector noted resident had been receiving specialized equipment at a required amount. The physician's order indicated that the dose the resident should be receiving was at a different. The ADOC confirmed with the inspector that the incorrect dose was being administered to the resident. [s. 6. (7)]

2. Resident #007 plan of care directed staff to put resident back to bed everyday after lunch and get up at 1630 hours daily . The resident was noted to be seated at the nurses station all afternoon sleeping on an identified dates in April,2014. The ADOC confirmed that resident should have been put to bed as per the plan of care. [s. 6. (7)]

3. The plan of care for resident #300 indicated that resident had a prescribed snack at morning nourishment pass. The nourishment pass was observed on an identified date in April, 2014 and these items were not provided to the resident. The resident confirmed this as well. The PSW who completed the nourishment pass confirmed that these items were not provided.
A)The plan of care for resident #100 indicated that a prescribed snack was to be provided to the resident at the morning nourishment pass. During the observed nourishment pass on an identified date in April, 2014, the snack was not provided to the resident or available on the nourishment cart. The plan of care for this resident also indicated that the resident was to be provided with chocolate milk at lunch. During the observed meal on an identified date in April, chocolate milk was not provided to resident.
B)The plan of care for resident #301 indicated that an adaptive device was to be provided at meals. During the observed meal on an identified date in April, 2014, the adaptive device was not provided to the resident as specified in the plan. [s. 6. (7)]

4. During an observation on an identified date in April, 2014 noon meal resident #011 was given a regular textured meal. A review of residents plan of care confirmed that the resident was to have a minced textured meal. The ED confirmed that the resident was given the wrong texture. [s. 6. (7)]

5. The plan of care for resident #005 confirmed that the resident was to have a specimen collected every two months since August 2013. There was no documentation on the resident's health record to confirm that the specimen was

obtained or sent to the laboratory from August 2013 until February 2014. The RN confirmed that a specimen was not taken during this time frame. [s. 6. (7)]

6. During the observed meal on an identified date in April, 2014, resident #001 was sitting at the table with fluids in front of the resident. The juices were noted to be thickened, however, the coffee and milk did not appear to be thickened. It was noted that the resident was to receive nectar consistency fluids according to the serving notes and the resident's plan of care. The inspector brought this to the attention of staff, who confirmed that it was not at the proper consistency and then added more thickener to thicken it to nectar consistency.
On an identified date in April, 2014, during the observed meal, a dietary aide was observed thickening a glass of milk without using a measuring spoon to ensure proper consistency. The FSM confirmed that staff should be using a measuring spoon and brought one out for the dietary aide to use to achieve proper consistency.
On an identified date in April, 2014, during the observed meal, a dietary aide thickened tea and coffee using a teaspoon and not measuring spoon. The inspector confirmed with dietary aide that the wrong spoon was used. The FSM confirmed on a previous observed day that the staff were to use a measuring spoon to thicken fluids.
On an identified date in April, 2014 resident #097 was noted on the serving notes to receive mashed potatoes at lunch and dinner however this was not provided during the observed lunch meal..[s. 6. (7)]

7. Resident #011 on an identified date in April, 2014 was observed by inspector #585 at the breakfast meal to have been served a glass of white milk that was partially consumed. Inspector was aware from reviewing residents plan of care that it indicated resident had an allergy to milk. The inspector confirmed that the milk was served to this resident by the dietary aide and confirmed by the dietary aide that they did not reference the plan of care prior to serving the milk or servery notes. [s. 6. (7)]
(585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

Order # / Ordre no : 004 **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, submit and implement a plan to ensure that when residents care needs change the plan of care is reviewed and revised. The plan should be submitted via email by May 16, 2014 to Lesley Edwards at lesley.edwards@ontario.ca at the Ministry of Health and Long Term Care, Hamilton, ON.

Grounds / Motifs :

1. 8. Previously issued as a CO on November 2013 and December 9, 2013

The licensee failed to ensure that residents were reassessed and the plans of care reviewed and revised at least every six months and at any other time when the residents' care needs change or care set out in the plan was no longer necessary.

A) Resident #003 was readmitted to the home from hospital on an identified date in March, 2014, with an identified pressure wound, and using a medical device. The written plan of care did not identify impaired skin integrity and did not identify that that the resident had a medical device. This information was confirmed by staff.

B) Resident #016's plan of care indicated resident was having newly identified pain and was complaining of pain and had been receiving pain medication whenever necessary. The resident was hospitalized and pain was not being controlled and subsequently was put on a new pain medication. Resident #016's plan of care was not revised to include pain management. The ADOC confirmed that the resident's plan of care should have been reviewed and revised to include pain managment. [s. 6. (10) (b)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(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).

Order / Ordre :

The licensee shall ensure that residents #003, #001, #012 and #094 are not served a meal until someone is available to provide assistance as required.

Grounds / Motifs :

1. 1. Previously issued as a CO on August 2013.

The licensee failed to ensure residents who required assistance with eating or drinking were served when someone was available to provide the assistance.

A) Resident #003 was observed to receive a pureed meal on an identified date in April, 2014. The resident was not offered assistance for 35 minutes. The plan of care indicates resident requires total assistance.
B) Resident #001 was observed to receive hot cereal at breakfast on an identified date in April, 2014. It was noted that the resident was not feeding themself and was not offered any assistance for 35 minutes when the PSW proceeded to feed resident their meal. The plan of care indicated the resident requires extensive assistance.
C) Resident # 012 was observed to receive hot cereal at breakfast on an identified date in April, 2014. The resident was not offered assistance for 30 minutes. The plan of care indicated the resident requires constant encouragement.
D) On an identified date in April, 2014, resident #094 had a plan of care to receive extensive to total assistance to eat meals. The resident was observed to receive their entree at 12:45 hours. The resident was not offered assistance until 13:15 hours as observed by Inspector #585. [s. 73. (2) (b)]

(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2013_201167_0036, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber.

Grounds / Motifs :

1. 1. Previously issued as a CO on December 2013.

The licensee failed to ensure that all drugs were administered to residents as prescribed by the prescriber.

During a review of the home's medication incident reports indicated that residents did not receive their prescribed medications.

A) Resident #021 was to receive their medication one capsule every 12 hours. The registered staff on duty on an identified date in February, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next shift.
B) Resident #010 was to receive their medication one capsule every 12 hours. The registered staff on duty on an identified date in February, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the day shift.
C) Resident #015 was to receive medication daily for seven days. Four doses were left in the vial and consequently the resident had to receive another course of medication for seven days.
D) Resident #041 was to receive their medication one capsule every eight hours. The registered staff on duty on an identified date in February, 2014 did not give

the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift.
E) Resident #042 was to receive 1700 hours scheduled medications on an identified date in March, 2014. The registered staff on duty did not give the medications as prescribed as were found in the strip pack by the nurse on the next day shift.
F) Resident #005 was to receive their medication one capsule every 12 hours. The registered staff on duty on an identified date in March, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift.
G) Resident #043 was to receive their medication half tablet three times a day. The registered staff on duty on an identified date in March, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift.
H) Resident #044 was to receive their pain medication daily. The registered staff on duty on an identified date in March, 2014 did not give the dose as prescribed as the medication was found in the blister pack by the nurse on the next day shift. [s. 131. (2)] (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 16, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of May, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Lesley Edwards

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