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
Jul 11, 2014	2014_240506_0016	H-000739-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

LESLEY EDWARDS (506), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), MARILYN TONE (167)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 17, 18, 19, 20 , 23, 24, 25, 26 and 27, 2014.

The following inspections were conducted concurrently with this inspection-Complaint Inspections log numbers; H-000537-14, H-000422-14, H-000536-14 and H-000488-14;Critical Incident Inspections log numbers-H-000660-14, H-000661-14 and H-000331-14 and Follow up Inspections were also conducted with this inspection; H-000724-14, H-000725-14, H-000726-14,H-000728-14, H-000729-14, H-000730-14, H-000731-14.

During the course of the inspection, the inspector(s) spoke with Provincial Director, Provincial Director Nursing Operations and Compliance, Executive Director (ED), Acting Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Food Service Manager, Acting Food Service Manager, Acting Director of Environmental Services, Lodge Director, Director of Recreation, Volunteers & Spiritual Care, Provincial Dietitian, Registered Dietitian (RD), Physiotherapist, Restorative Care worker, Registered nursing staff, Personal Support Workers (PSW), Housekeeping and laundry staff, dietary staff, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas and reviewed relevant documents including, but not limited to: policies and procedures, meeting minutes, menus, recipes, staff files and health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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. 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures developed for cleaning resident bedroom floors were implemented.

Vinyl flooring surfaces were observed to be dirty in appearance, with particles such as paint chips stuck or embedded in the floor in resident rooms 300, 301, 302, 304, 306, 308, 313, 312 over the course of the inspection. The same conditions were present in the same rooms during inspections conducted on November 14 and 19, 2013 and January 29 and 30, 2014. Non-compliance was issued for both visits.

The home's housekeepers reported that the floors were difficult to clean and that the day to day mopping was not successful in removing the ground in dirt or the embedded particles, regardless of the cleaning products available to them. The housekeepers reported that they have not used any floor machines in the bedrooms or have been given any new cleaning directions since the last inspection. The maintenance person was asked to demonstrate the effectiveness of their floor scrubbing machine in room 301. The machine was not able to remove all of the the embedded particles or the ground in dirt. However, if the machine were to be used several more times, with the appropriate products, it appeared possible that the floor conditions would improve.

The home's floor care policies and procedures were general in nature, describing the same routine for various different flooring types. In particular, policies #ES C-15-25, ES C-15-10, ES C-15-40 and ES C-15-20 were developed for floor care, describing that floor buffing was to be completed weekly or more often in high traffic areas. The maintenance records identified that the rooms identified above were all last buffed in May 2013. The floor care program for the vinyl flooring material in the above noted rooms has not been implemented. [s. 87. (2) (a)]

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the residents' plans of care set out clear directions to staff and others who provide direct care to the residents.

A) Resident #050's plan of care stated that they are to receive their preferred juice at the morning and the afternoon snack and yogurt at the morning snack and a half of a sandwich at the afternoon snack along with 125 ml nutritional supplement at morning snack, lunch and dinner. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, only listed that the resident is to receive 125 ml of assorted juices at snacks and a half of a sandwich at afternoon snack. It did not list their preferred juice, yogurt, or the nutritional supplement. During an observation of the morning beverage pass on an identified date in June, 2014, the resident was only offered juice or pop. The resident did not receive their preferred juice, yogurt or their nutritional supplement as per the resident's plan of care.

B) Resident #021's plan of care stated that staff are to encourage intake of snacks from snack cart due to the resident's weight loss, in addition to providing the resident with a beverage and snack upon wakening. The resident's snack service report,

which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, does not list any specific direction for staff regarding morning beverage pass. [s. 6. (1) (c)]

2. The licensee did not ensure that staff collaborated in the assessment, development and implementation of the residents' plans of care.

A) Resident #021's plan of care stated that the resident often sleeps in past breakfast so staff are to encourage food and beverage intake upon waking. During observation of morning beverage pass on an identified date in June, 2014, a staff member informed another staff member who was completing the snack pass that the resident enjoyed pudding and a banana every morning upon waking. The resident's snack service report and the plan of care did not list any of the resident's preferences. The frontline staff and RD did not collaborate in the development and implementation of the resident's plan of care.

B) Resident #013 returned from the hospital on an identified date in March, 2014. A progress note made by the ADOC on an identified date in April, 2014, stated that the resident's Power of Attorney (POA) requested that the resident be reassessed by the RD due to a potential medical diagnosis while in the hospital. The progress note also stated that a referral was to be made to the RD by the ADOC. Interview with the RD on an identified date in June, 2014, confirmed a referral was never received. Interview with the ADOC and ED confirmed that the referral form could not be found. The ADOC did not collaborate with the RD regarding a dietary assessment as per POA request. [s. 6. (4)]

3. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) Resident #019 reported that they were transferred improperly on an identified date in March, 2014 causing the resident to have pain. The home had a meeting with the resident and resident's POA and discussed a plan to ensure that this did not happen again as there had been previous concerns of improper transferring prior to this incident. They decided that they would send a referral to the physiotherapist, restorative care worker and the staff educator to provide further training to the staff on proper transferring of this resident. As of June 26, 2014 there had not been any

further implementation, development or follow-up of the education to date as verified by the DOC.

B) Resident #050's plan of care stated that they are to avoid certain food products as per Speech Language Pathologist (SLP) recommendations. The resident's plan of care also stated that the resident is to receive these food items. (586) [s. 6. (4) (b)]

4. 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 #013's plan of care directed staff to ensure that their specialized wheelchair cushion is applied properly. On two occasions as documented in the progress notes and confirmed by Registered staff on an identified date in May, 2014, and June, 2014 the specialized cushion was not applied appropriately. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their nutrition plan of care.

A)Resident #053's plan of care and meal service report stated that the resident is to receive chocolate milk at meals. The resident did not receive chocolate milk during breakfast service on two identified dates in June, 2014, or during lunch service on an identified date in June, 2014. Resident #054's plan of care stated that the resident is to receive chocolate milk at breakfast and morning beverage pass. The resident did not receive chocolate milk at breakfast on two identified dates June, 2014.

B) Resident #006 and #056's plan of care and meal service reports stated that the residents are to have cream, butter, margarine or gravy added to their food. These residents did not have any cream, margarine, butter or gravy added to their food during lunch service on an identified date in June, 2014. The cook confirmed that none of these items were added to any of the residents' meals as special dietary interventions.

C) Resident #013's plan of care and meal service report stated that the resident is to receive 250 ml of their preferred juice at their meals. The resident did not receive their preferred juice at breakfast and lunch on an identified date in June, 2014, dinner on an identified date in June, 2014, and breakfast on an identified date in June, 2014.

D) Resident #057's plan of care and meal service report stated that the resident is to

receive yogurt at breakfast. The resident did not receive yogurt during breakfast service on an identified date in June, 2014.

E) Resident #058's plan of care and meal service report stated that the resident is to receive crustless bread. During breakfast and lunch on an identified date in June, 2014, the resident received toast and bread with crusts. Resident #007's meal service report stated the resident is to receive crustless sandwiches only. During lunch on an identified date in June, 2014, the resident received a sandwich with crusts.

F) Resident #051's plan of care and snack service report stated that, the resident is to receive a muffin at morning beverage pass. The resident was not offered and did not receive a muffin during morning beverage pass on an identified date in June, 2014. There was no muffin on the beverage cart for the resident. This was confirmed by the PSW delivering the drinks and snacks.

G) Resident #050's plan of care stated that the resident is to receive their preferred juice, and yogurt at morning beverage pass as well as nutritional supplement. The resident was offered labelled juice during morning snack pass on an identified date in June, 2014, however was not offered and did not receive their preferred juice, yogurt, or their nutritional supplement. These items were not listed on the resident's snack service report that the staff are to refer to during beverage and snack pass. The PSW completing the morning beverage pass on an identified date in June, 2014, did not refer to the snack service report binder at all while performing this duty.

H) Resident #053, #062, #063 and #064's plans of care stated that they are to receive prune juice at breakfast. The residents did not receive prune juice during breakfast service on an identified date in June, 2014. [s. 6. (7)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that their Admission, Transfer and Discharges and Death Policy was complied with.

Resident #008 returned from the hospital on an identified date in May 2014 and did not have a Resident Assessment Instrument-Material Data Set (RAI-MDS) Significant Change in Condition Assessment completed despite having a change in physical status. Resident #008 also did not have a Head to Toe Assessment completed at the time of re-admission. Resident #021 also returned from the hospital on an identified date in May 2014 and did not have a Head to Toe Assessment completed at the time of re-admission. Policy #LTC-B-80 [Admissions, Transfers, Discharges and Death] revised August 2012 stated that appropriate assessments are to be completed by the Interdisciplinary Team. The Assessment Schedule stated that on re-admission from hospital, MDS 2.0 Significant Change in Condition are to be completed as well as a Head to Toe Assessment. This was confirmed on June 25, 2014 by the ADOC. [s. 8. (1)]

2. The licensee did not ensure that their Weight Management Policy was complied with.

The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] stated that if a weight loss or gain is 2.0 kilograms (kg) or greater from the preceding month, a re-weigh is to be completed immediately. The following residents had weight changes greater than 2.0 kg in one month and re-weighs were not completed: resident #011 had a weight loss of 3.7 kg, resident #016 had a weight loss of 2.6 kg, resident #054 had a weight loss of 3.6, and resident #061 has a weight loss of 8.4 kg.

3. The licensee did not ensure that their Fall Policy was complied with.

The home's policy [Fall Interventions Risk Management (FIRM) Program, LTC-C-E-60 revised date March 2014] was complied with related to resident #005 and resident #008. The policy directed the staff to complete a Post Fall Action Checklist completed.
- Resident #005 had three falls; during the months of May and June, 2014 and no Post Fall Action Checklist for residents who have fallen.
-Resident #008 had a fall on an identified date in June, 2014 and no Post Fall Action Checklist completed.
- The DOC confirmed that the staff were not completing the checklist as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 005 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. 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident #004 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Observation of resident #004 on an identified date in June, 2014 noted that the resident had a skin tear on their body and another skin tear just below. While reviewing resident #004's plan of care, there was no documentation to indicate that the resident's skin tears received immediate treatment and interventions to promote healing. Interview with the RN and PSW on an identified date in June, 2014

confirmed that they were not aware of the skin tears that were observed on an identified date in June, 2014. [s. 50. (2) (b) (ii)]

2. The licensee did not ensure that the equipment, devices and positioning aids referred to subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A) Resident #006 was identified as having a pressure area on an identified date in June, 2014. It was also noted that the resident had been identified as having a blackened area on an identified date in May, 2014. The resident's pressure ulcer is currently a stage X wound.
- Resident #006 was noted to have a large mass on an identified area. The resident was assessed to have moderate pain daily on an identified date on the April, 2014 MDS assessment and takes regular pain medication twice per day as well as narcotic analgesic when required. The resident also sustained an injury in April 2014, had not been eating well and spends most of their time in bed.
- During an interview with the "Wound Care Champion", they confirmed that the resident would benefit from a pressure relief surface, but indicated that there were none available at the home.
- During an interview with the DOC, it was confirmed that the home did not have a pressure relief surface that was available for use by resident #006 to manage pressure and pain. [s. 50. (2) (c)]

3. The licensee did not ensure that a resident who was dependant on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #022 was observed seated in their broda chair on an identified date in June, 2014 from 1200 hours until 1600 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before lunch time.
B) Resident #023 was observed seated in their tilt wheelchair on an identified date in June, 2014 from 0930 hours until 1230 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before 0930 when the resident was gotten up for the day. According to the MDS quarterly assessment completed on an identified date in April, 2014, the resident's pressure

ulcer rating (PURS) score was five, which indicated the resident was at risk for impaired skin integrity. [s. 50. (2) (d)]

Additional Required Actions:

CO # - 006 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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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).

Findings/Faits saillants :

1. The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's Cook's Meal Production Daily Temperature Record indicated that cold foods should be maintained at 4 degree Celsius. Temperatures were taken nearing the end of lunch service on an identified date in June, 2014. The regular ham salad sandwich was probed at 11.8 degrees Celsius, the pureed sandwich at 5.9 degrees Celsius, and the marinated vegetable salad at 6.2 degrees Celsius. [s. 73. (1) 6.]

2. The licensee did not ensure each resident was provided with eating aids and assistive devices to safely eat and drink as comfortable and independently as possible.

A) Resident #014's meal service report, which is used by staff to be kept aware of residents' specific needs during dining, stated that the resident needed assistive devices for their beverages at meals. The resident received their fluids in regular cups without assistive devices during breakfast and lunch service on an identified date in June, 2014.

B) Resident #064's meal service report stated that they are to receive an adaptive device for fluids. The resident received their fluids without a adaptive device during lunch service on an identified date in June, 2014.

C) Resident #050's plan of care and meal service report stated that the resident is to receive soup using an adaptive device as per SLP recommendations to support eating and swallowing. The resident received their soup in a bowl during lunch service on an identified date in June, 2014.

D) Resident #060's meal service report stated that the resident is to receive a adaptive device for beverages at meals. The resident received their fluids without an adaptive device during breakfast and lunch service on an identified date in June, 2014.

E) Resident #054's meal service report, and resident #050's plan of care and meal service report, stated that the residents are to receive lipped plates for all meals. The residents received regular plates during lunch service on an identified date in June, 2014. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 007 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:
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. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
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).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

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. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to

participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 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. The licensee did not ensure that the rights of residents were fully respected and promoted with respect to being given access to protected outdoor areas in order to enjoy outdoor activity.

The home established an outdoor area for resident use more than 10 years ago by having a deck and elevated boardwalk built on one side of the building, just outside the main lounge. At one time, residents were able to independently use the outdoor space and were able to manipulate the exit door, which had a crash bar. Over time, the home did not maintain the condition of the deck and boardwalk, creating safety issues preventing residents from using the space without supervision. In addition, as the mobility status of residents changed, the management of the home did not consider amending or replacing the door to the outdoor space with a door that could be used independently by residents in wheelchairs or walkers.

A family member raised concerns during a family council meeting in March 2014 indicating that they would like to have access to the outdoor space but could not as the door would automatically lock behind them when on the deck or was kept magnetically locked on the inside. Discussion with an activation staff member revealed that residents are escorted outside only when staff or family are available. Reasons were due to the fact that the outdoor area was not secured in any way, with access to the main road and because of the poor maintenance of the deck and boardwalk. In response to the residents, the management staff stated that the door to the outside was a fire department requirement and that nothing could be done. No door alternatives were sought which would continue to meet fire department regulations, such as a door with an automatic door opening device and a magnetic release button on the outside to be able to regain entry. [s. 3. (1)]

2. The licensee did not ensure that resident #014 was protected from abuse by a co-resident.
-On an identified date in June, 2014, the home submitted a critical incident report related to a abuse that took place at the home involving resident #014 and #015. During a review of the progress notes for both residents, it was confirmed that resident #014 had been abused by resident #015.
- It was noted in the plan of care for resident #015 that they had a previous history of abuse towards female staff and co-residents. [s. 3. (1) 2.]

3. The licensee did not ensure that every resident had his or her choices respected.

During morning beverage pass on an identified date in June, 2014, two PSWs were discussing going to the kitchen to get a banana for resident #012 who likes to have one every day. Resident #052, who was right nearby, overhead this, and when asked

if they wanted a drink or snack, stated that they wanted a banana. The PSW stated they did not have any bananas. When the resident requested one again, the PSW said they would just give the resident a drink because they knew they would take it. The PSW then said they were going to the kitchen to get a banana for the other resident. Resident #052 did not receive a banana as per their request. [s. 3. (1) 19.]

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 rights of residents are fully respected and promoted and residents have their choices respected. To ensure that all residents are protected from abuse by a co-resident, to be implemented voluntarily.

WN #7: 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 resident-staff communication and response system was not available in every area accessible by residents. An outdoor space immediately outside of the main lounge was identified to be used by residents and was not equipped with an activation station. [s. 17. (1) (e)]

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 and ensuring that a resident-staff communication response system available in every area accessible by residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that the lighting requirements set out in the Table to this section were maintained.

Resident bathrooms and corridors were measured on March 5, 2013 and again during this inspection. Non-compliance was previously issued on March 15, 2013. Other areas of the home may also be deficient but were not tested.

-Random resident washrooms were measured with a hand held portable light meter on March 5, 2013 and June 25, 2014. Lights were turned on and allowed to burn until completely illuminated (approx. 5 minutes). The resident washrooms in the home all had lights mounted to the wall above the sink. These lights were shielded with a wood valence which prevented the room from being adequately illuminated. Depending on the age of the light bulbs, various washrooms produced different lux levels. Toilet areas were measured to be between 30-50 lux (above toilet seat), sink areas were adequate and measured between 300-600 lux and the centre of the rooms were between 40-100 lux. The minimum required level for the room is 215.28 lux.
-The lounge area directly in front of the nurse's station, which was a pass through area and also considered a corridor was illuminated with pot lights, which produced a cone of light down to the floor. The lights did not adequately illuminate the space. The illumination level below the bulbs was measured to be 400 lux and only 80-90 lux between each pot light. The pot lights were spaced 6 feet apart. The requirement is 215.28 of continuous consistent lighting.
-The corridors in the home were illuminated with fluorescent tubes, spaced 10-12 feet apart. The illumination level below several of the corridor ceiling fixtures was 600-800 lux and 50-70 lux between the light fixtures. The measurement was taken 36 inches above the floor or at waist height, with the light source in front of the meter. Resident bedroom doors were closed to minimize the amount of natural light coming from the windows in the bedrooms. The lighting level required is 215.28 lux of continuous consistent lighting.

Discussion held with the Administrator on June 24, 2014 revealed that no actions have been taken to date with respect to having the home lighting levels increased with the exception of having a new lighting fixture installed in one bathroom as a trial. [s. 18.]

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 meets the lighting requirements as set out in the table are maintained, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #016 was protected from abuse by a staff member.

On an identified date in May, 2014, the ED observed a staff member physically abusing resident #016. The staff member was noted to physically abuse the resident while providing care.
- Inspector #536 conducted a review of the training and education records for staff at the home and the staff member's employee file. It was noted that there were no records found to indicate that the accused staff member had received their mandatory annual prevention of abuse and neglect training. (536) [s. 19. (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 protected from abuse by anyone, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the pain management program at the home provided for strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids.

A) A review of the home's policy titled "Pain Management and Symptom Management – LTC-E-80 last revised August 2012" revealed that the policy did not include identification of non-pharmacological interventions, equipment, supplies, devices and assistive aids to assist residents with their pain management. The policy referred only to pain management with regards to analgesic administration.

B) Resident #006 was noted to have sustained an injury on an identified date in April 2014, had a large mass on the their body that was noted to be malignant and was causing pain, had a stage x pressure ulcer on an area of their body and two pressure ulcers on another identified area and was noted to remain in bed most of the day. The resident was noted to require regular use of narcotic and non-narcotic analgesia.
- The document that the home refers to as the care plan for resident #006 under "Alteration in Comfort: Pain" did not include identification of any non-pharmacological interventions to manage the resident's pain or to assist in their comfort. [s. 52. (1) 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 the home provides for strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that strategies were developed and implemented to respond to resident #015's demonstration of a responsive behaviour towards female co-residents.

A) During a review of the progress notes in resident #015's health file, it was noted that resident #015 displayed responsive behaviours toward female residents and female staff.
- The progress notes indicated that resident #015 displayed responsive behaviours towards female staff on identified dates in September, November, December, 2013 and responsive behaviours towards female co-residents in December, 2013, March, and June, 2014.
- A review took place of the document that the home refers to as the care plan, that was confirmed by the Resident Assessment Instrument Co-ordinator to be the care plan in place to direct care when the incident occurred. The care plan did not address the resident's responsive behaviour towards female co-residents and only indicated responsive behaviours towards staff. This care plan was dated as last reviewed on an identified date in April, 2014.
- The only intervention that was in place on an identified date in April, 2014 care plan indicated for staff to document when the resident was inappropriate with female staff, divert the resident's attention and remind not to touch. The care plan does not address the risk to female co-residents at the home, nor were there interventions in place to prevent or mitigate those risks to female co-residents. [s. 53. (4) (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 strategies are developed and implemented for preventing responsive behaviours, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that the residents with the following weight changes are assessed, and that actions are taken and outcomes are evaluated;
1. A change of 5 per cent body weight, or more, over one month.

A) Resident #011's weight since admission decreased 6.3 per cent over one month. Review of the resident's clinical health records and interview with the RD on June 23, 2014, confirmed that the resident was not assessed for significant weight loss.

B) Resident #061's weight decreased 12.4 per cent over one month. Review of the resident's clinical health records on June 25, 2014, confirmed that the resident was not assessed for significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 with significant weight changes are evaluated, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance for the following;

-Exterior areas of the home, specifically the deck and elevated wooden boardwalk located on the one side of the building to which residents have access. The deck and boardwalk were observed to be in a state of neglect, with rotten wood planks, loose posts, raised nails, rough surfaces and uneven boards. No plans were in place for any remedial maintenance at the time of inspection. No documentation was available for review with respect to when any routine and preventive inspections had been conducted.
-Interior doors, specifically resident bathroom doors. During the inspection, doors in #309, 316, 328, 415 were unable to close or had to be pushed with pressure to close or open. Several of the hinges appeared to have pulled away from the door frame. Twenty of the doors also had a small nickle-sized hole in the door which was caused by a door stop attached to the hinges. The door stops were ineffective. A door in room #320 had a large hole (3 cm by 12 cm) in the door. [s. 90. (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 there are schedules and procedures in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Medications were not stored in a medication cart that was secure and locked on an identified date in June, 2014.

A) On an identified date in June, 2014, the medication cart was left unattended and unlocked outside of the nurses station and the Registered staff had left to go down the hall to give another resident their medications. The inspector was able to open the drawers of the medication cart. The ADOC confirmed that the medication cart was left unlocked and unattended. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the training and orientation program at the home was implemented.

A) The home has a binder that is titled" Orientation and Staff Development Toolkit 2012" that sets out the home's policies and procedures related to education and training. The policies indicated the requirements of the program, including the tracking systems to be used to record attendance at the education sessions.
During a review of the records provided by the home related to orientation and training for 2013 and 2014, it was noted that there was no clear record related to what education was provided and which staff attended these education sessions.
- It was noted that the lead person for education and training was no longer available at the home to provide information related to this program. It was noted in the home's training manual that there was a spreadsheet that was to have been completed to identify statistics related to education provided and attendance. Staff and managers at the home were unable to provide this information and were not able to confirm that this tracking had been done.
- It was noted that the home was not able to produce any clear record keeping or tracking related to the training and orientation program at the home. [s. 216. (1)]

2. The licensee did not ensure that at least annually, the home's training and orientation program was evaluated and updated in accordance with evidence-based practices.

It was noted that the lead for the training and orientation program at the home was not available to interview during this inspection and staff and managers at the home were not able to produce any record of an evaluation having been completed as required. [s. 216. (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 a training and orientation program at the home is implemented and that the training and orientation program is evaluated, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in home`s infection prevention and control program related to hand hygiene.

On an identified date in June, 2014 a Registered Practical Nurse (RPN) was observed doing the morning medication administration for five residents. The nurse did not wash or sanitize their hands in between pouring and administering medications to residents. On the same day at the lunch medication administration, the same RPN was observed administering medication to seven residents and once again did not wash or sanitize their hands in between pouring and administering medications.
-On an identified date in June, 2014 at lunch service, a PSW was observed in the dining room serving soup with their thumb positioned inside the bowl. No hand washing was observed during distribution of the tray of soup. [s. 229. (4)]

2. During afternoon snack pass on an identified date in June, 2014, two PSWs were observed touching cookies with their bare hands and serving these to the residents. During morning beverage pass on an identified date in June, 2014, a PSW was observed playing with their hair, then continued serving residents without having washed their hands. [s. 229. (4)]

3. The licensee did not ensure that on every shift, resident's symptoms were recorded and that immediate action was taken as required.

The home's infection control policy (IPC-J-10) titled "Infection Surveillance" dated February 2014 requires Registered staff to "assess and document symptoms in the resident's progress notes". In addition, the home's infection control policies require Registered staff to complete a form titled "Home Area Daily Infection Control Surveillance" (IPC-J-10-15 ON) on a daily basis. The data collected on the form is

required to be analyzed by the home's infection control designate for trends and to prevent or mitigate possible outbreaks. However, during the course of the inspection, the home management staff were not able to produce the Home Area Daily Infection Control Surveillance form for the months of March or April 2014. The management was not able to demonstrate that they took immediate steps to mitigate or prevent the spread of any infections that may have been present during the months of March and April 2014.

On April 22, 2014, confirmation of a positive case of Influenza B was received by Public Health for a resident in the retirement home, which is connected to the long-term care home. An official outbreak of Influenza was declared on April 23, 2014 for both retirement and long term care. The management of the long-term care home began a respiratory line listing, identifying 8 residents who were already symptomatic by April 23, 2014. Outbreak control measures were instituted on April 23, 2014, whereby contact precautions were re-enforced, residents were offered anti-viral medication, group activities cancelled, families contacted and notices posted. No documentary evidence (i.e. Home Area Daily Infection Control Surveillance Form) was available to confirm that residents were being monitored for symptoms prior to the outbreak and measures instituted so that the spread of infection could be contained. During the inspection, the health care records for 2 out of the 8 affected residents were identified by registered staff to have flu-like symptoms on or before April 20, 2014. One resident was reported to have coughing and congestion on April 14, 2014 and often visited residents on the retirement home side. The resident was later identified to be positive with Influenza B. The other resident was diagnosed with shallow breathing on April 19, 2014 and was sent to hospital for advanced symptoms on April 21, 2014. The resident was also positively diagnosed with Influenza B. [s. 229. (5) (b)]

Additional Required Actions:

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

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

A) There was no record to indicate that recommendations made by the council regarding dietary concerns were responded to in writing within ten days. The ED confirmed that the council was not responded to within the ten days. [s. 57. (2)]

WN #18: 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 did not ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

The home did not ensure that resident's heights were taken annually as evidenced by review of the home's clinical records. This was confirmed by Registered and non-registered staff and the ED. The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] does not include the requirement to take the resident's heights annually. This was confirmed by the ED. [s. 68. (2) (e) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

The recipe for the pureed ham salad sandwich was not followed. The recipe stated that to prepare the pureed bread, the cook was to break bread into a baking pan, add milk and mix, then bake this in the oven for 15 minutes. The cook was then to melt margarine and stir this into the bread, cool it, and reheat prior to service. Interview with the cook on June 19, 2014, confirmed that to make the pureed sandwiches, they added ham salad filling, bread, and margarine into a food processor, and served cold. The cook confirmed that the recipe was not followed. [s. 72. (3) (a)]

WN #20: 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,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that policies were implemented related to reporting and locating of residents' lost clothing and personal items.

A) When asked for a copy of the home's policy related to handling of missing items of clothing and other articles, "Nova policy, ES D-20-30 dated as last reviewed January 2012" was provided. The policy indicated the following:
- All lost clothing concerns from family or visitors were to be brought to the attention of the Resident Services Co-ordinator (RSC).
- The missing item was to be recorded on the "Client Service Response Form or the "Missing Clothing Checklist" by the RSC.
- The nursing department was to search the home area and the laundry staff were to search the laundry area and report back to the RSC.
- The RSC was then to report the results back to the person who made the complaint.
- During interviews with nursing and laundry staff, it was confirmed that a different form is currently being used ("Missing Laundry/Article Form") and staff provided conflicting information related to how to use this form and to whom it should be submitted.
- There was no policy to support the use of this form.
- One staff member indicated that the form is filled in by nursing and then tacked to the cork board in the laundry area. This staff member indicated that if the missing article is found, the form is filled in indicating that the article was found and when and is placed in the laundry binder at the nurses station. If the article is not found the staff member did not know of any protocol to follow.
-There was no consistent approach to dealing with residents' lost clothing or missing articles. [s. 89. (1) (a) (iv)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the pharmacy service provider and a registered dietitian meets annually to evaluate the effectiveness of the medication management system in the home:

On June 25, 2014, review of the program evaluation on Medication Management identified that the Medical Director, pharmacy service provider and the RD were not involved in the annual evaluation of the medication management program. This was confirmed by the DOC on June 26, 2014. [s. 116. (1)]

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. 131. (2)	CO #006	2014_240506_0009	536
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #001	2014_189120_0007	120
O.Reg 79/10 s. 31. (3)	CO #002	2014_240506_0009	506
O.Reg 79/10 s. 52. (2)	CO #002	2014_240506_0010	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2014_210169_0002	506
O.Reg 79/10 s. 73. (2)	CO #005	2014_240506_0009	586
O.Reg 79/10 s. 77. (1)	CO #001	2014_240506_0009	586

Issued on this 23rd day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LESLEY EDWARDS (506), BERNADETTE SUSNIK (120), CATHIE ROBITAILLE (536), JESSICA PALADINO (586), MARILYN TONE (167)
Inspection No. / No de l'inspection :	2014_240506_0016
Log No. / Registre no:	H-000739-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 11, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall submit a plan describing how and when the lighting levels in the home will be assessed and increased to meet current legislative requirements.
The plan shall be submitted by August 15, 2014 and implemented by a mutually agreed upon date which will be determined once the plan is received for review.
The plan shall be submitted electronically to Bernadette Susnik at Bernadette.Susnik@ontario.ca.

The licensee shall:
1. Have the vinyl flooring material (in rooms 300, 301, 302, 304, 306, 308, 313, 312) evaluated by a flooring specialist to determine appropriate cleaning solutions, equipment and frequency necessary to keep the floor clean (free of ground in dirt and stuck on particles)
2. Clean the flooring material as per the specialist's recommendations.
3. Update the home's floor care procedures as per the specialist's recommendations with respect to routines, chemicals and equipment necessary to clean the type of flooring materials in the home. The procedures shall be implemented.
4. Educate all housekeeping staff with respect to the expectations of cleaning different flooring material in the home and the updated floor care procedures.
To be complied with by August 15, 2014.

Grounds / Motifs :

1. The licensee did not ensure that procedures developed for cleaning resident bedroom floors were implemented.

Vinyl flooring surfaces were observed to be dirty in appearance, with particles such as paint chips stuck or embedded in the floor in resident rooms 300, 301, 302, 304, 306, 308, 313, 312 over the course of the inspection. The same conditions were present in the same rooms during inspections conducted on November 14 and 19, 2013 and January 29 and 30, 2014. Non-compliance was issued for both visits.

The home's housekeepers reported that the floors were difficult to clean and that the day to day mopping was not successful in removing the ground in dirt or the embedded particles, regardless of the cleaning products available to them. The housekeepers reported that they have not used any floor machines in the bedrooms or have been given any new cleaning directions since the last inspection. The maintenance person was asked to demonstrate the effectiveness of their floor scrubbing machine in room 301. The machine was not able to remove all of the the embedded particles or the ground in dirt. However, if the machine were to be used several more times, with the appropriate products, it appeared possible that the floor conditions would improve.

The home's floor care policies and procedures were general in nature, describing the same routine for various different flooring types. In particular, policies #ES C-15-25, ES C-15-10, ES C-15-40 and ES C-15-20 were developed for floor care, describing that floor buffing was to be completed weekly or more often in high traffic areas. The maintenance records identified that the rooms identified above were all last buffed in May 2013. The floor care program for the vinyl flooring material in the above noted rooms has not been implemented.
(120)

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_210169_0002, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all aspects of residents' #050 and #021's plans of care, including care plans and snack service reports, are clear and consistent, and are updated to include all dietary interventions, to provide clear direction to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. Previously issued as a CO on March 2014.

The licensee did not ensure that the residents' plans of care set out clear directions to staff and others who provide direct care to the residents.

A) Resident #050's plan of care stated that they are to receive their preferred juice at the morning and the afternoon snack and yogurt at the morning snack and a half of a sandwich at the afternoon snack along with 125 ml nutritional supplement at morning snack, lunch and dinner. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, only listed that the resident is to receive 125 ml of assorted juices at snacks and a half of a sandwich at afternoon snack. It did not list their preferred juice, yogurt, or the nutritional supplement. During an observation of the morning beverage pass on an identified date in June, 2014, the resident was only offered juice or pop. The resident did not receive their preferred juice, yogurt or their nutritional supplement as per the resident's plan of care.

B) Resident #021's plan of care stated that staff are to encourage intake of snacks from snack cart due to the resident's weight loss, in addition to providing the resident with a beverage and snack upon wakening. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, does not list any specific direction for staff regarding morning beverage pass. (586)

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the interdisciplinary team collaborate in the assessment, development and implementation of resident #021, #013, #019 and #050.

Grounds / Motifs :

1. Previously issued as a VPC on November 2013.

The licensee did not ensure that staff collaborated in the assessment, development and implementation of the residents' plans of care.

A) Resident #021's plan of care stated that the resident often sleeps in past breakfast so staff are to encourage food and beverage intake upon waking. During observation of morning beverage pass on an identified date in June, 2014, a staff member informed another staff member who was completing the snack pass that the resident enjoyed pudding and a banana every morning upon waking. The resident's snack service report and the plan of care did not list any of the resident's preferences. The frontline staff and RD did not collaborate in the development and implementation of the resident's plan of care.

B) Resident #013 returned from the hospital on an identified date in March, 2014. A progress note made by the ADOC on an identified date in April, 2014, stated that the resident's Power of Attorney (POA) requested that the resident

be reassessed by the RD due to a potential medical diagnosis while in the hospital. The progress note also stated that a referral was to be made to the RD by the ADOC. Interview with the RD on an identified date in June, 2014, confirmed a referral was never received. Interview with the ADOC and ED confirmed that the referral form could not be found. The ADOC did not collaborate with the RD regarding a dietary assessment as per POA request. (586)

2. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) Resident #019 reported that they were transferred improperly on an identified date in March, 2014 causing the resident to have pain. The home had a meeting with the resident and resident's POA and discussed a plan to ensure that this did not happen again as there had been previous concerns of improper transferring prior to this incident. They decided that they would send a referral to the physiotherapist, restorative care worker and the staff educator to provide further training to the staff on proper transferring of this resident. As of June 26, 2014 there had not been any further implementation, development or follow-up of the education to date as verified by the DOC.

B) Resident #050's plan of care stated that they are to avoid certain food products as per Speech Language Pathologist (SLP) recommendations. The resident's plan of care also stated that the resident is to receive these food items.
(506)

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0009, CO #003; 2014_240506_0009, CO #004;

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 care set out in the plan of care is provided to resident #053, #054, #006, #056, #013, #057, #058, #051, #050, #062, #063 and #064 as specified in the plan of care.

Grounds / Motifs :

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

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

A)Resident #053's plan of care and meal service report stated that the resident is to receive chocolate milk at meals. The resident did not receive chocolate milk during breakfast service on two identified dates in June, 2014, or during lunch service on an identified date in June, 2014. Resident #054's plan of care stated that the resident is to receive chocolate milk at breakfast and morning beverage pass. The resident did not receive chocolate milk at breakfast on two identified dates June, 2014.

B) Resident #006 and #056's plan of care and meal service reports stated that the residents are to have cream, butter, margarine or gravy added to their food. These residents did not have any cream, margarine, butter or gravy added to their food during lunch service on an identified date in June, 2014. The cook confirmed that none of these items were added to any of the residents' meals as special dietary interventions.

C) Resident #013's plan of care and meal service report stated that the resident is to receive 250 ml of their preferred juice at their meals. The resident did not receive their preferred juice at breakfast and lunch on an identified date in June, 2014, dinner on an identified date in June, 2014, and breakfast on an identified date in June, 2014.

D) Resident #057's plan of care and meal service report stated that the resident is to receive yogurt at breakfast. The resident did not receive yogurt during breakfast service on an identified date in June, 2014.

E) Resident #058's plan of care and meal service report stated that the resident is to receive crustless bread. During breakfast and lunch on an identified date in June, 2014, the resident received toast and bread with crusts. Resident #007's meal service report stated the resident is to receive crustless sandwiches only. During lunch on an identified date in June, 2014, the resident received a sandwich with crusts.

F) Resident #051's plan of care and snack service report stated that, the resident is to receive a muffin at morning beverage pass. The resident was not offered and did not receive a muffin during morning beverage pass on an identified date in June, 2014. There was no muffin on the beverage cart for the resident. This was confirmed by the PSW delivering the drinks and snacks.

G) Resident #050's plan of care stated that the resident is to receive their preferred juice, and yogurt at morning beverage pass as well as nutritional supplement. The resident was offered labelled juice during morning snack pass on an identified date in June, 2014, however was not offered and did not receive their preferred juice, yogurt, or their nutritional supplement. These items were not listed on the resident's snack service report that the staff are to refer to during beverage and snack pass. The PSW completing the morning beverage pass on an identified date in June, 2014, did not refer to the snack service report binder at all while performing this duty.

H) Resident #053, #062, #063 and #064's plans of care stated that they are to receive prune juice at breakfast. The residents did not receive prune juice during breakfast service on an identified date in June, 2014. (586)

2. 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 #013's plan of care directed staff to ensure that their specialized wheelchair cushion is applied properly. On two occasions as documented in the progress notes and confirmed by Registered staff on an identified date in May, 2014, and June, 2014 the specialized cushion was not applied appropriately. (506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 15, 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. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home is complying with their policies related to Admissions, Transfers, Discharges and Deaths, Weight Management Policy and Fall Intervention Risk Management.

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that their Weight Management Policy was complied with.

The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] stated that if a weight loss or gain is 2.0 kilograms (kg) or greater from the preceding month, a re-weigh is to be completed immediately. The following residents had weight changes greater than 2.0 kg in one month and re-weighs were not completed: resident #011 had a weight loss of 3.7 kg, resident #016 had a weight loss of 2.6 kg, resident #054 had a weight loss of 3.6 , and resident #061 has a weight loss of 8.4 kg. (586)

2. The licensee did not ensure that their Admission, Transfer and Discharges and Death Policy was complied with.

Resident #008 returned from the hospital on an identified date in May 2014 and did not have a Resident Assessment Instrument-Material Data Set (RAI-MDS)

Significant Change in Condition Assessment completed despite having a change in physical status. Resident #008 also did not have a Head to Toe Assessment completed at the time of re-admission. Resident #021 also returned from the hospital on an identified date in May 2014 and did not have a Head to Toe Assessment completed at the time of re-admission. Policy #LTC-B-80 [Admissions, Transfers, Discharges and Death] revised August 2012 stated that appropriate assessments are to be completed by the Interdisciplinary Team. The Assessment Schedule stated that on re-admission from hospital, MDS 2.0 Significant Change in Condition are to be completed as well as a Head to Toe Assessment. This was confirmed on June 25, 2014 by the Assistant Director of Care . (536)

3. The licensee did not ensure that their Fall Policy was complied with.

The home's policy [Fall Interventions Risk Management (FIRM) Program, LTC-C-E-60 revised date March 2014] was complied with related to resident #005 and resident #008. The policy directed the staff to complete a Post Fall Action Checklist completed.
- Resident #005 had three falls; during the months of May and June, 2014 and no Post Fall Action Checklist for residents who have fallen.
-Resident #008 had a fall on an identified date in June, 2014 and no Post Fall Action Checklist completed.
- The DOC confirmed that the staff were not completing the checklist as per the home's policy. (506)

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0010, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that resident #004 receives immediate treatment and interventions for all skin tears.
The licensee shall ensure that resident #006 receives equipment, devices and positioning aides to relieve pressure and treat pressure ulcers.
The licensee shall ensure that resident #022 and #023 who are dependent on staff for repositioning are repositioned every two hours as required depending on their condition.

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that resident #004 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Observation of resident #004 on an identified date in June, 2014 noted that the resident had a skin tear on their body and another skin tear just below. While reviewing resident #004's plan of care, there was no documentation to indicate that the resident's skin tears received immediate treatment and interventions to promote healing. Interview with the RN and PSW on an identified date in June, 2014 confirmed that they were not aware of the skin tears that were observed on an identified date in June, 2014.

(506)

2. The licensee did not ensure that the equipment, devices and positioning aids referred to subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A) Resident #006 was identified as having a pressure area on an identified date in June, 2014. It was also noted that the resident had been identified as having a blackened area on an identified date in May, 2014. The resident's pressure ulcer is currently a stage X wound.
- Resident #006 was noted to have a large mass on an identified area. The resident was assessed to have moderate pain daily on an identified date on the April, 2014 MDS assessment and takes regular pain medication twice per day as well as narcotic analgesic when required. The resident also sustained an injury

in April 2014, had not been eating well and spends most of their time in bed.
- During an interview with the "Wound Care Champion", they confirmed that the resident would benefit from a pressure relief surface, but indicated that there were none available at the home.
- During an interview with the DOC, it was confirmed that the home did not have a pressure relief surface that was available for use by resident #006 to manage pressure and pain.

(167)

3. The licensee did not ensure that a resident who was dependant on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #022 was observed seated in their broda chair on an identified date in June, 2014 from 1200 hours until 1600 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before lunch time.
B) Resident #023 was observed seated in their tilt wheelchair on an identified date in June, 2014 from 0930 hours until 1230 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before 0930 when the resident was gotten up for the day. According to the MDS quarterly assessment completed on an identified date in April, 2014, the resident's pressure ulcer rating (PURS) score was five, which indicated the resident was at risk for impaired skin integrity. (506)

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

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will;
1. Ensure that all foods and fluids are served at safe and palatable temperatures and,
2. Ensure all residents are provided with eating aides and assistive devices required to safely eat and drink as comfortable and independently as possible at meals. The plan is to be submitted to Long-Term Care Homes Inspector Jessica Paladino by August 15, 2014 at: Jessica.Paladino@ontario.ca

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's Cook's Meal Production Daily Temperature Record indicated that cold foods should be maintained at 4 degrees Celsius Temperatures were taken nearing the end of lunch service on an identified date in June, 2014. The regular ham salad sandwich was probed at 11.8 degrees Celsius, the pureed sandwich at 5.9 degrees Celsius, and the marinated vegetable salad at 6.2 degrees Celsius. (586)

2. Previously issued as a CO on November 2013.

The licensee did not ensure each resident was provided with eating aids and assistive devices to safely eat and drink as comfortable and independently as possible.

A) Resident #014's meal service report, which is used by staff to be kept aware of residents' specific needs during dining, stated that the resident needed assistive devices for their beverages at meals. The resident received their fluids in regular cups without assistive devices during breakfast and lunch service on an identified date in June, 2014.

B) Resident #064's meal service report stated that they are to receive an adaptive device for fluids. The resident received their fluids without a adaptive device during lunch service on an identified date in June, 2014.

C) Resident #050's plan of care and meal service report stated that the resident

is to receive soup using an adaptive device as per SLP recommendations to support eating and swallowing. The resident received their soup in a bowl during lunch service on an identified date in June, 2014.

D) Resident #060's meal service report stated that the resident is to receive a adaptive device for beverages at meals. The resident received their fluids without an adaptive device during breakfast and lunch service on an identified date in June, 2014.

E) Resident #054's meal service report, and resident #050's plan of care and meal service report, stated that the residents are to receive lipped plates for all meals. The residents received regular plates during lunch service on an identified date in June, 2014. (586)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 11th day of July, 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

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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection/ Genre d'inspection
Jul 23, 2014;	2014_240506_0016 (A1)	H-000739-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

LESLEY EDWARDS (506) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): June 17, 18, 19, 20 , 23, 24, 25, 26 and 27, 2014.

The following inspections were conducted concurrently with this inspection-Complaint Inspections log numbers; H-000537-14, H-000422-14, H-000536-14 and H-000488-14;Critical Incident Inspections log numbers-H-000660-14, H-000661-14 and H-000331-14 and Follow up Inspections were also conducted with this inspection; H-000724-14, H-000725-14, H-000726-14,H-000728-14, H-000729-14, H-000730-14, H-000731-14.

During the course of the inspection, the inspector(s) spoke with Provincial Director, Provincial Director Nursing Operations and Compliance, Executive Director (ED), Acting Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Food Service Manager, Acting Food Service Manager, Acting Director of Environmental Services, Lodge Director, Director of Recreation, Volunteers & Spiritual Care, Provincial Dietitian, Registered Dietitian (RD), Physiotherapist, Restorative Care worker, Registered nursing staff, Personal Support Workers (PSW), Housekeeping and laundry staff, dietary staff, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas and reviewed relevant documents including, but not limited to: policies and procedures, meeting minutes, menus, recipes, staff files and health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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. 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures developed for cleaning resident bedroom floors were implemented.

Vinyl flooring surfaces were observed to be dirty in appearance, with particles such as paint chips stuck or embedded in the floor in resident rooms 300, 301, 302, 304, 306, 308, 313, 312 over the course of the inspection. The same conditions were present in the same rooms during inspections conducted on November 14 and 19, 2013 and January 29 and 30, 2014. Non-compliance was issued for both visits.

The home's housekeepers reported that the floors were difficult to clean and that the day to day mopping was not successful in removing the ground in dirt or the embedded particles, regardless of the cleaning products available to them. The housekeepers reported that they have not used any floor machines in the bedrooms or have been given any new cleaning directions since the last inspection. The maintenance person was asked to demonstrate the effectiveness of their floor scrubbing machine in room 301. The machine was not able to remove all of the the embedded particles or the ground in dirt. However, if the machine were to be used several more times, with the appropriate products, it appeared possible that the floor conditions would improve.

The home's floor care policies and procedures were general in nature, describing the same routine for various different flooring types. In particular, policies #ES C-15-25, ES C-15-10, ES C-15-40 and ES C-15-20 were developed for floor care, describing that floor buffing was to be completed weekly or more often in high traffic areas. The maintenance records identified that the rooms identified above were all last buffed in May 2013. The floor care program for the vinyl flooring material in the above noted rooms has not been implemented. [s. 87. (2) (a)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the residents' plans of care set out clear directions to staff and others who provide direct care to the residents.

A) Resident #050's plan of care stated that they are to receive their preferred juice at the morning and the afternoon snack and yogurt at the morning snack and a half of a sandwich at the afternoon snack along with 125 ml nutritional supplement at morning snack, lunch and dinner. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, only listed that the resident is to receive 125 ml of assorted juices at snacks and a half of a sandwich at afternoon snack. It did not list their preferred juice, yogurt, or the nutritional supplement. During an observation of the morning beverage pass on an identified date in June, 2014, the resident was only offered juice or pop. The resident did not receive their preferred juice, yogurt or their nutritional supplement as per the resident's plan of care.

B) Resident #021's plan of care stated that staff are to encourage intake of snacks from snack cart due to the resident's weight loss, in addition to providing the resident with a beverage and snack upon wakening. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special

dietary needs and interventions, does not list any specific direction for staff regarding morning beverage pass. [s. 6. (1) (c)]

2. The licensee did not ensure that staff collaborated in the assessment, development and implementation of the residents' plans of care.

A) Resident #021's plan of care stated that the resident often sleeps in past breakfast so staff are to encourage food and beverage intake upon waking. During observation of morning beverage pass on an identified date in June, 2014, a staff member informed another staff member who was completing the snack pass that the resident enjoyed pudding and a banana every morning upon waking. The resident's snack service report and the plan of care did not list any of the resident's preferences. The frontline staff and RD did not collaborate in the development and implementation of the resident's plan of care.

B) Resident #013 returned from the hospital on an identified date in March, 2014. A progress note made by the ADOC on an identified date in April, 2014, stated that the resident's Power of Attorney (POA) requested that the resident be reassessed by the RD due to a potential medical diagnosis while in the hospital. The progress note also stated that a referral was to be made to the RD by the ADOC. Interview with the RD on an identified date in June, 2014, confirmed a referral was never received. Interview with the ADOC and ED confirmed that the referral form could not be found. The ADOC did not collaborate with the RD regarding a dietary assessment as per POA request. [s. 6. (4)]

3. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) Resident #019 reported that they were transferred improperly on an identified date in March, 2014 causing the resident to have pain. The home had a meeting with the resident and resident's POA and discussed a plan to ensure that this did not happen again as there had been previous concerns of improper transferring prior to this incident. They decided that they would send a referral to the physiotherapist, restorative care worker and the staff educator to provide further training to the staff on proper transferring of this resident. As of June 26, 2014 there had not been any further implementation, development or follow-up of the education to date as verified by the DOC.

B) Resident #050's plan of care stated that they are to avoid certain food products as per Speech Language Pathologist (SLP) recommendations. The resident's plan of care also stated that the resident is to receive these food items. (586) [s. 6. (4) (b)]

4. 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 #013's plan of care directed staff to ensure that their specialized wheelchair cushion is applied properly. On two occasions as documented in the progress notes and confirmed by Registered staff on an identified date in May, 2014, and June, 2014 the specialized cushion was not applied appropriately. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their nutrition plan of care.

A)Resident #053's plan of care and meal service report stated that the resident is to receive chocolate milk at meals. The resident did not receive chocolate milk during breakfast service on two identified dates in June, 2014, or during lunch service on an identified date in June, 2014. Resident #054's plan of care stated that the resident is to receive chocolate milk at breakfast and morning beverage pass. The resident did not receive chocolate milk at breakfast on two identified dates June, 2014.

B) Resident #006 and #056's plan of care and meal service reports stated that the residents are to have cream, butter, margarine or gravy added to their food. These residents did not have any cream, margarine, butter or gravy added to their food during lunch service on an identified date in June, 2014. The cook confirmed that none of these items were added to any of the residents' meals as special dietary interventions.

C) Resident #013's plan of care and meal service report stated that the resident is to receive 250 ml of their preferred juice at their meals. The resident did not receive their preferred juice at breakfast and lunch on an identified date in June, 2014, dinner on an identified date in June, 2014, and breakfast on an identified date in June, 2014.

D) Resident #057's plan of care and meal service report stated that the resident is to receive yogurt at breakfast. The resident did not receive yogurt during breakfast service on an identified date in June, 2014.

E) Resident #058's plan of care and meal service report stated that the resident is to receive crustless bread. During breakfast and lunch on an identified date in June, 2014, the resident received toast and bread with crusts. Resident #007's meal service report stated the resident is to receive crustless sandwiches only. During lunch on an identified date in June, 2014, the resident received a sandwich with crusts.

F) Resident #051's plan of care and snack service report stated that, the resident is to receive a muffin at morning beverage pass. The resident was not offered and did not receive a muffin during morning beverage pass on an identified date in June, 2014. There was no muffin on the beverage cart for the resident. This was confirmed by the PSW delivering the drinks and snacks.

G) Resident #050's plan of care stated that the resident is to receive their preferred juice, and yogurt at morning beverage pass as well as nutritional supplement. The resident was offered labelled juice during morning snack pass on an identified date in June, 2014, however was not offered and did not receive their preferred juice, yogurt, or their nutritional supplement. These items were not listed on the resident's snack service report that the staff are to refer to during beverage and snack pass. The PSW completing the morning beverage pass on an identified date in June, 2014, did not refer to the snack service report binder at all while performing this duty.

H) Resident #053, #062, #063 and #064's plans of care stated that they are to receive prune juice at breakfast. The residents did not receive prune juice during breakfast service on an identified date in June, 2014. [s. 6. (7)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002,003,004

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that their Admission, Transfer and Discharges and Death Policy was complied with.

Resident #008 returned from the hospital on an identified date in May 2014 and did not have a Resident Assessment Instrument-Material Data Set (RAI-MDS) Significant Change in Condition Assessment completed despite having a change in physical status. Resident #008 also did not have a Head to Toe Assessment completed at the time of re-admission. Resident #021 also returned from the hospital on an identified date in May 2014 and did not have a Head to Toe Assessment completed at the time of re-admission. Policy #LTC-B-80 [Admissions, Transfers, Discharges and Death] revised August 2012 stated that appropriate assessments are to be completed by the Interdisciplinary Team. The Assessment Schedule stated that on re-admission from hospital, MDS 2.0 Significant Change in Condition are to be completed as well as a Head to Toe Assessment. This was confirmed on June 25, 2014 by the ADOC. [s. 8. (1)]

2. The licensee did not ensure that their Weight Management Policy was complied with.

The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] stated that if a weight loss or gain is 2.0 kilograms (kg) or greater from the preceding month, a re-weigh is to be completed immediately. The following residents had weight changes greater than 2.0 kg in one month and re-weighs were not completed: resident #011 had a weight loss of 3.7 kg, resident #016 had a weight loss of 2.6 kg, resident #054 had a weight loss of 3.6, and resident #061 has a weight loss of 8.4 kg.

3. The licensee did not ensure that their Fall Policy was complied with.

The home's policy [Fall Interventions Risk Management (FIRM) Program, LTC-C-E-60 revised date March 2014] was complied with related to resident #005 and resident #008. The policy directed the staff to complete a Post Fall Action Checklist completed.
- Resident #005 had three falls; during the months of May and June, 2014 and no Post Fall Action Checklist for residents who have fallen.
-Resident #008 had a fall on an identified date in June, 2014 and no Post Fall Action Checklist completed.
- The DOC confirmed that the staff were not completing the checklist as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

WN #4: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident #004 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Observation of resident #004 on an identified date in June, 2014 noted that the resident had a skin tear on their body and another skin tear just below. While reviewing resident #004's plan of care, there was no documentation to indicate that the resident's skin tears received immediate treatment and interventions to promote healing. Interview with the RN and PSW on an identified date in June, 2014 confirmed that they were not aware of the skin tears that were observed on an

identified date in June, 2014. [s. 50. (2) (b) (ii)]

2. The licensee did not ensure that the equipment, devices and positioning aids referred to subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A) Resident #006 was identified as having a pressure area on an identified date in June, 2014. It was also noted that the resident had been identified as having a blackened area on an identified date in May, 2014. The resident's pressure ulcer is currently a stage X wound.
- Resident #006 was noted to have a large mass on an identified area. The resident was assessed to have moderate pain daily on an identified date on the April, 2014 MDS assessment and takes regular pain medication twice per day as well as narcotic analgesic when required. The resident also sustained an injury in April 2014, had not been eating well and spends most of their time in bed.
- During an interview with the "Wound Care Champion", they confirmed that the resident would benefit from a pressure relief surface, but indicated that there were none available at the home.
- During an interview with the DOC, it was confirmed that the home did not have a pressure relief surface that was available for use by resident #006 to manage pressure and pain. [s. 50. (2) (c)]

3. The licensee did not ensure that a resident who was dependant on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #022 was observed seated in their broda chair on an identified date in June, 2014 from 1200 hours until 1600 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before lunch time.
B) Resident #023 was observed seated in their tilt wheelchair on an identified date in June, 2014 from 0930 hours until 1230 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before 0930 when the resident was gotten up for the day. According to the MDS quarterly assessment completed on an identified date in April, 2014, the resident's pressure ulcer rating (PURS) score was five, which indicated the resident was at risk for impaired skin integrity. [s. 50. (2) (d)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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).

Findings/Faits saillants :

1. The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's Cook's Meal Production Daily Temperature Record indicated that cold foods should be maintained at 4 degree Celsius. Temperatures were taken nearing the end of lunch service on an identified date in June, 2014. The regular ham salad sandwich was probed at 11.8 degrees Celsius, the pureed sandwich at 5.9 degrees Celsius, and the marinated vegetable salad at 6.2 degrees Celsius. [s. 73. (1) 6.]

2. The licensee did not ensure each resident was provided with eating aids and assistive devices to safely eat and drink as comfortable and independently as possible.

A) Resident #014's meal service report, which is used by staff to be kept aware of residents' specific needs during dining, stated that the resident needed assistive devices for their beverages at meals. The resident received their fluids in regular cups without assistive devices during breakfast and lunch service on an identified date in June, 2014.

B) Resident #064's meal service report stated that they are to receive an adaptive device for fluids. The resident received their fluids without a adaptive device during lunch service on an identified date in June, 2014.

C) Resident #050's plan of care and meal service report stated that the resident is to receive soup using an adaptive device as per SLP recommendations to support eating and swallowing. The resident received their soup in a bowl during lunch service on an identified date in June, 2014.

D) Resident #060's meal service report stated that the resident is to receive a adaptive device for beverages at meals. The resident received their fluids without an adaptive device during breakfast and lunch service on an identified date in June, 2014.

E) Resident #054's meal service report, and resident #050's plan of care and meal service report, stated that the residents are to receive lipped plates for all meals. The residents received regular plates during lunch service on an identified date in June, 2014. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 007

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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:
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. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
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).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).
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 indep

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 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. The licensee did not ensure that the rights of residents were fully respected and promoted with respect to being given access to protected outdoor areas in order to enjoy outdoor activity.

The home established an outdoor area for resident use more than 10 years ago by having a deck and elevated boardwalk built on one side of the building, just outside the main lounge. At one time, residents were able to independently use the outdoor space and were able to manipulate the exit door, which had a crash bar. Over time, the home did not maintain the condition of the deck and boardwalk, creating safety issues preventing residents from using the space without supervision. In addition, as the mobility status of residents changed, the management of the home did not consider amending or replacing the door to the outdoor space with a door that could be used independently by residents in wheelchairs or walkers.

A family member raised concerns during a family council meeting in March 2014 indicating that they would like to have access to the outdoor space but could not as the door would automatically lock behind them when on the deck or was kept magnetically locked on the inside. Discussion with an activation staff member

revealed that residents are escorted outside only when staff or family are available. Reasons were due to the fact that the outdoor area was not secured in any way, with access to the main road and because of the poor maintenance of the deck and boardwalk. In response to the residents, the management staff stated that the door to the outside was a fire department requirement and that nothing could be done. No door alternatives were sought which would continue to meet fire department regulations, such as a door with an automatic door opening device and a magnetic release button on the outside to be able to regain entry. [s. 3. (1)]

2. The licensee did not ensure that resident #014 was protected from abuse by a co-resident.
-On an identified date in June, 2014, the home submitted a critical incident report related to a abuse that took place at the home involving resident #014 and #015. During a review of the progress notes for both residents, it was confirmed that resident #014 had been abused by resident #015.
- It was noted in the plan of care for resident #015 that they had a previous history of abuse towards female staff and co-residents. [s. 3. (1) 2.]

3. The licensee did not ensure that every resident had his or her choices respected.

During morning beverage pass on an identified date in June, 2014, two PSWs were discussing going to the kitchen to get a banana for resident #012 who likes to have one every day. Resident #052, who was right nearby, overhead this, and when asked if they wanted a drink or snack, stated that they wanted a banana. The PSW stated they did not have any bananas. When the resident requested one again, the PSW said they would just give the resident a drink because they knew they would take it. The PSW then said they were going to the kitchen to get a banana for the other resident. Resident #052 did not receive a banana as per their request. [s. 3. (1) 19.]

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 rights of residents are fully respected and promoted and residents have their choices respected. To ensure that all residents are protected from abuse by a co-resident, to be implemented voluntarily.

WN #7: 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 resident-staff communication and response system was not available in every area accessible by residents. An outdoor space immediately outside of the main lounge was identified to be used by residents and was not equipped with an activation station. [s. 17. (1) (e)]

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 and ensuring that a resident-staff communication response system available in every area accessible by residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that the lighting requirements set out in the Table to this section were maintained.

Resident bathrooms and corridors were measured on March 5, 2013 and again during this inspection. Non-compliance was previously issued on March 15, 2013. Other areas of the home may also be deficient but were not tested.

-Random resident washrooms were measured with a hand held portable light meter on March 5, 2013 and June 25, 2014. Lights were turned on and allowed to burn until completely illuminated (approx. 5 minutes). The resident washrooms in the home all had lights mounted to the wall above the sink. These lights were shielded with a wood valence which prevented the room from being adequately illuminated. Depending on the age of the light bulbs, various washrooms produced different lux levels. Toilet areas were measured to be between 30-50 lux (above toilet seat), sink areas were adequate and measured between 300-600 lux and the centre of the rooms were between 40-100 lux. The minimum required level for the room is 215.28 lux.
-The lounge area directly in front of the nurse's station, which was a pass through area and also considered a corridor was illuminated with pot lights, which produced a cone of light down to the floor. The lights did not adequately illuminate the space. The illumination level below the bulbs was measured to be 400 lux and only 80-90 lux between each pot light. The pot lights were spaced 6 feet apart. The requirement is 215.28 of continuous consistent lighting.
-The corridors in the home were illuminated with fluorescent tubes, spaced 10-12 feet apart. The illumination level below several of the corridor ceiling fixtures was 600-800 lux and 50-70 lux between the light fixtures. The measurement was taken 36 inches above the floor or at waist height, with the light source in front of the meter. Resident bedroom doors were closed to minimize the amount of natural light coming from the windows in the bedrooms. The lighting level required is 215.28 lux of continuous consistent lighting.

Discussion held with the Administrator on June 24, 2014 revealed that no actions have been taken to date with respect to having the home lighting levels increased with the exception of having a new lighting fixture installed in one bathroom as a trial. [s. 18.]

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 meets the lighting requirements as set out in the table are maintained, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #016 was protected from abuse by a staff member.

On an identified date in May, 2014, the ED observed a staff member physically abusing resident #016. The staff member was noted to physically abuse the resident while providing care.
- Inspector #536 conducted a review of the training and education records for staff at the home and the staff member's employee file. It was noted that there were no records found to indicate that the accused staff member had received their mandatory annual prevention of abuse and neglect training. (536) [s. 19. (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 protected from abuse by anyone, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the pain management program at the home provided for strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids.

A) A review of the home's policy titled "Pain Management and Symptom Management – LTC-E-80 last revised August 2012" revealed that the policy did not include identification of non-pharmacological interventions, equipment, supplies, devices and assistive aids to assist residents with their pain management. The policy referred only to pain management with regards to analgesic administration.

B) Resident #006 was noted to have sustained an injury on an identified date in April 2014, had a large mass on the their body that was noted to be malignant and was causing pain, had a stage x pressure ulcer on an area of their body and two pressure ulcers on another identified area and was noted to remain in bed most of the day. The resident was noted to require regular use of narcotic and non-narcotic analgesia.
- The document that the home refers to as the care plan for resident #006 under "Alteration in Comfort: Pain" did not include identification of any non-pharmacological interventions to manage the resident's pain or to assist in their comfort. [s. 52. (1) 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 the home provides for strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that strategies were developed and implemented to respond to resident #015's demonstration of a responsive behaviour towards female co-residents.

A) During a review of the progress notes in resident #015's health file, it was noted that resident #015 displayed responsive behaviours toward female residents and female staff.
- The progress notes indicated that resident #015 displayed responsive behaviours towards female staff on identified dates in September, November, December, 2013 and responsive behaviours towards female co-residents in December, 2013, March, and June, 2014.
- A review took place of the document that the home refers to as the care plan, that was confirmed by the Resident Assessment Instrument Co-ordinator to be the care plan in place to direct care when the incident occurred. The care plan did not address the resident's responsive behaviour towards female co-residents and only indicated responsive behaviours towards staff. This care plan was dated as last reviewed on an identified date in April, 2014.
- The only intervention that was in place on an identified date in April, 2014 care plan indicated for staff to document when the resident was inappropriate with female staff, divert the resident's attention and remind not to touch. The care plan does not address the risk to female co-residents at the home, nor were there interventions in place to prevent or mitigate those risks to female co-residents. [s. 53. (4) (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 strategies are developed and implemented for preventing responsive behaviours, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that the residents with the following weight changes are assessed, and that actions are taken and outcomes are evaluated;
1. A change of 5 per cent body weight, or more, over one month.

A) Resident #011's weight since admission decreased 6.3 per cent over one month. Review of the resident's clinical health records and interview with the RD on June 23, 2014, confirmed that the resident was not assessed for significant weight loss.

B) Resident #061's weight decreased 12.4 per cent over one month. Review of the resident's clinical health records on June 25, 2014, confirmed that the resident was not assessed for significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 with significant weight changes are evaluated, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance for the following;

-Exterior areas of the home, specifically the deck and elevated wooden boardwalk located on the one side of the building to which residents have access. The deck and boardwalk were observed to be in a state of neglect, with rotten wood planks, loose posts, raised nails, rough surfaces and uneven boards. No plans were in place for any remedial maintenance at the time of inspection. No documentation was available for review with respect to when any routine and preventive inspections had been conducted.
-Interior doors, specifically resident bathroom doors. During the inspection, doors in #309, 316, 328, 415 were unable to close or had to be pushed with pressure to close or open. Several of the hinges appeared to have pulled away from the door frame. Twenty of the doors also had a small nickle-sized hole in the door which was caused by a door stop attached to the hinges. The door stops were ineffective. A door in room #320 had a large hole (3 cm by 12 cm) in the door. [s. 90. (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 there are schedules and procedures in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Medications were not stored in a medication cart that was secure and locked on an identified date in June, 2014.

A) On an identified date in June, 2014, the medication cart was left unattended and unlocked outside of the nurses station and the Registered staff had left to go down the hall to give another resident their medications. The inspector was able to open the drawers of the medication cart. The ADOC confirmed that the medication cart was left unlocked and unattended. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the training and orientation program at the home was implemented.

A) The home has a binder that is titled" Orientation and Staff Development Toolkit 2012" that sets out the home's policies and procedures related to education and training. The policies indicated the requirements of the program, including the tracking systems to be used to record attendance at the education sessions.
During a review of the records provided by the home related to orientation and training for 2013 and 2014, it was noted that there was no clear record related to what education was provided and which staff attended these education sessions.
- It was noted that the lead person for education and training was no longer available at the home to provide information related to this program. It was noted in the home's training manual that there was a spreadsheet that was to have been completed to identify statistics related to education provided and attendance. Staff and managers at the home were unable to provide this information and were not able to confirm that this tracking had been done.
- It was noted that the home was not able to produce any clear record keeping or tracking related to the training and orientation program at the home. [s. 216. (1)]

2. The licensee did not ensure that at least annually, the home's training and orientation program was evaluated and updated in accordance with evidence-based practices.

It was noted that the lead for the training and orientation program at the home was not available to interview during this inspection and staff and managers at the home were not able to produce any record of an evaluation having been completed as required. [s. 216. (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 a training and orientation program at the home is implemented and that the training and orientation program is evaluated, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in home`s infection prevention and control program related to hand hygiene.

On an identified date in June, 2014 a Registered Practical Nurse (RPN) was observed doing the morning medication administration for five residents. The nurse did not wash or sanitize their hands in between pouring and administering medications to residents. On the same day at the lunch medication administration, the same RPN was observed administering medication to seven residents and once again did not wash or sanitize their hands in between pouring and administering medications.
-On an identified date in June, 2014 at lunch service, a PSW was observed in the dining room serving soup with their thumb positioned inside the bowl. No hand washing was observed during distribution of the tray of soup. [s. 229. (4)]

2. During afternoon snack pass on an identified date in June, 2014, two PSWs were observed touching cookies with their bare hands and serving these to the residents. During morning beverage pass on an identified date in June, 2014, a PSW was observed playing with their hair, then continued serving residents without having washed their hands. [s. 229. (4)]

3. The licensee did not ensure that on every shift, resident's symptoms were recorded

and that immediate action was taken as required.

The home's infection control policy (IPC-J-10) titled "Infection Surveillance" dated February 2014 requires Registered staff to "assess and document symptoms in the resident's progress notes". In addition, the home's infection control policies require Registered staff to complete a form titled "Home Area Daily Infection Control Surveillance" (IPC-J-10-15 ON) on a daily basis. The data collected on the form is required to be analyzed by the home's infection control designate for trends and to prevent or mitigate possible outbreaks. However, during the course of the inspection, the home management staff were not able to produce the Home Area Daily Infection Control Surveillance form for the months of March or April 2014. The management was not able to demonstrate that they took immediate steps to mitigate or prevent the spread of any infections that may have been present during the months of March and April 2014.

On April 22, 2014, confirmation of a positive case of Influenza B was received by Public Health for a resident in the retirement home, which is connected to the long-term care home. An official outbreak of Influenza was declared on April 23, 2014 for both retirement and long term care. The management of the long-term care home began a respiratory line listing, identifying 8 residents who were already symptomatic by April 23, 2014. Outbreak control measures were instituted on April 23, 2014, whereby contact precautions were re-enforced, residents were offered anti-viral medication, group activities cancelled, families contacted and notices posted. No documentary evidence (i.e. Home Area Daily Infection Control Surveillance Form) was available to confirm that residents were being monitored for symptoms prior to the outbreak and measures instituted so that the spread of infection could be contained. During the inspection, the health care records for 2 out of the 8 affected residents were identified by registered staff to have flu-like symptoms on or before April 20, 2014. One resident was reported to have coughing and congestion on April 14, 2014 and often visited residents on the retirement home side. The resident was later identified to be positive with Influenza B. The other resident was diagnosed with shallow breathing on April 19, 2014 and was sent to hospital for advanced symptoms on April 21, 2014. The resident was also positively diagnosed with Influenza B. [s. 229. (5) (b)]

Additional Required Actions:

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

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

A) There was no record to indicate that recommendations made by the council regarding dietary concerns were responded to in writing within ten days. The ED confirmed that the council was not responded to within the ten days. [s. 57. (2)]

WN #18: 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 did not ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

The home did not ensure that resident's heights were taken annually as evidenced by review of the home's clinical records. This was confirmed by Registered and non-registered staff and the ED. The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] does not include the requirement to take the resident's heights annually. This was confirmed by the ED. [s. 68. (2) (e) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

The recipe for the pureed ham salad sandwich was not followed. The recipe stated that to prepare the pureed bread, the cook was to break bread into a baking pan, add milk and mix, then bake this in the oven for 15 minutes. The cook was then to melt margarine and stir this into the bread, cool it, and reheat prior to service. Interview with the cook on June 19, 2014, confirmed that to make the pureed sandwiches, they added ham salad filling, bread, and margarine into a food processor, and served cold. The cook confirmed that the recipe was not followed. [s. 72. (3) (a)]

WN #20: 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, (a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that policies were implemented related to reporting and locating of residents' lost clothing and personal items.

A) When asked for a copy of the home's policy related to handling of missing items of clothing and other articles, "Nova policy, ES D-20-30 dated as last reviewed January 2012" was provided. The policy indicated the following:
- All lost clothing concerns from family or visitors were to be brought to the attention of the Resident Services Co-ordinator (RSC).
- The missing item was to be recorded on the "Client Service Response Form or the "Missing Clothing Checklist" by the RSC.
- The nursing department was to search the home area and the laundry staff were to search the laundry area and report back to the RSC.
- The RSC was then to report the results back to the person who made the complaint.
- During interviews with nursing and laundry staff, it was confirmed that a different form is currently being used ("Missing Laundry/Article Form") and staff provided conflicting information related to how to use this form and to whom it should be submitted.
- There was no policy to support the use of this form.
- One staff member indicated that the form is filled in by nursing and then tacked to the cork board in the laundry area. This staff member indicated that if the missing article is found, the form is filled in indicating that the article was found and when and is placed in the laundry binder at the nurses station. If the article is not found the staff member did not know of any protocol to follow.
-There was no consistent approach to dealing with residents' lost clothing or missing articles. [s. 89. (1) (a) (iv)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the pharmacy service provider and a registered dietitian meets annually to evaluate the effectiveness of the medication management system in the home:

On June 25, 2014, review of the program evaluation on Medication Management identified that the Medical Director, pharmacy service provider and the RD were not involved in the annual evaluation of the medication management program. This was confirmed by the DOC on June 26, 2014. [s. 116. (1)]

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. 131. (2)	CO #006	2014_240506_0009	536
LTCHA, 2007 s. 15. (2)	CO #001	2014_189120_0007	120
O.Reg 79/10 s. 31. (3)	CO #002	2014_240506_0009	506
O.Reg 79/10 s. 52. (2)	CO #002	2014_240506_0010	167
LTCHA, 2007 s. 6. (7)	CO #002	2014_210169_0002	506
O.Reg 79/10 s. 73. (2)	CO #005	2014_240506_0009	586
O.Reg 79/10 s. 77. (1)	CO #001	2014_240506_0009	586

Issued on this 24 day of July 2014 (A1)

[redacted]

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LESLEY EDWARDS (506) - (A1)

Inspection No. / No de l'inspection : 2014_240506_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000739-14 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jul 23, 2014;(A1)

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

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

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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall submit a plan describing how and when the lighting levels in the home will be assessed and increased to meet current legislative requirements.
The plan shall be submitted by August 15, 2014 and implemented by a mutually agreed upon date which will be determined once the plan is received for review. The plan shall be submitted electronically to Bernadette Susnik at Bernadette.Susnik@ontario.ca.

The licensee shall:
1. Have the vinyl flooring material (in rooms 300, 301, 302, 304, 306, 308, 313, 312) evaluated by a flooring specialist to determine appropriate cleaning solutions, equipment and frequency necessary to keep the floor clean (free of ground in dirt and stuck on particles)
2. Clean the flooring material as per the specialist's recommendations.
3. Update the home's floor care procedures as per the specialist's recommendations with respect to routines, chemicals and equipment necessary to clean the type of flooring materials in the home. The procedures shall be implemented.
4. Educate all housekeeping staff with respect to the expectations of cleaning different flooring material in the home and the updated floor care procedures.

To be complied with by August 15, 2014.

Grounds / Motifs :

1. The licensee did not ensure that procedures developed for cleaning resident bedroom floors were implemented.

Vinyl flooring surfaces were observed to be dirty in appearance, with particles such as paint chips stuck or embedded in the floor in resident rooms 300, 301, 302, 304, 306, 308, 313, 312 over the course of the inspection. The same conditions were present in the same rooms during inspections conducted on November 14 and 19, 2013 and January 29 and 30, 2014. Non-compliance was issued for both visits.

The home's housekeepers reported that the floors were difficult to clean and that the day to day mopping was not successful in removing the ground in dirt or the embedded particles, regardless of the cleaning products available to them. The housekeepers reported that they have not used any floor machines in the bedrooms or have been given any new cleaning directions since the last inspection. The maintenance person was asked to demonstrate the effectiveness of their floor scrubbing machine in room 301. The machine was not able to remove all of the the embedded particles or the ground in dirt. However, if the machine were to be used several more times, with the appropriate products, it appeared possible that the floor conditions would improve.

The home's floor care policies and procedures were general in nature, describing the same routine for various different flooring types. In particular, policies #ES C-15-25, ES C-15-10, ES C-15-40 and ES C-15-20 were developed for floor care, describing that floor buffing was to be completed weekly or more often in high traffic areas. The maintenance records identified that the rooms identified above were all last buffed in May 2013. The floor care program for the vinyl flooring material in the above noted rooms has not been implemented.
(120)

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

Aug 15, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_210169_0002, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all aspects of residents' #050 and #021's plans of care, including care plans and snack service reports, are clear and consistent, and are updated to include all dietary interventions, to provide clear direction to staff and others who provide direct care to the residents.

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

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

Grounds / Motifs :

1. Previously issued as a CO on March 2014.

The licensee did not ensure that the residents' plans of care set out clear directions to staff and others who provide direct care to the residents.

A) Resident #050's plan of care stated that they are to receive their preferred juice at the morning and the afternoon snack and yogurt at the morning snack and a half of a sandwich at the afternoon snack along with 125 ml nutritional supplement at morning snack, lunch and dinner. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, only listed that the resident is to receive 125 ml of assorted juices at snacks and a half of a sandwich at afternoon snack. It did not list their preferred juice, yogurt, or the nutritional supplement. During an observation of the morning beverage pass on an identified date in June, 2014, the resident was only offered juice or pop. The resident did not receive their preferred juice, yogurt or their nutritional supplement as per the resident's plan of care.

B) Resident #021's plan of care stated that staff are to encourage intake of snacks from snack cart due to the resident's weight loss, in addition to providing the resident with a beverage and snack upon wakening. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, does not list any specific direction for staff regarding morning beverage pass. (586)

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

Sep 15, 2014(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the interdisciplinary team collaborate in the assessment, development and implementation of resident #021, #013, #019 and #050.

Grounds / Motifs :

1. Previously issued as a VPC on November 2013.

The licensee did not ensure that staff collaborated in the assessment, development and implementation of the residents' plans of care.

A) Resident #021's plan of care stated that the resident often sleeps in past breakfast so staff are to encourage food and beverage intake upon waking. During observation of morning beverage pass on an identified date in June, 2014, a staff member informed another staff member who was completing the snack pass that the resident enjoyed pudding and a banana every morning upon waking. The resident's snack service report and the plan of care did not list any of the resident's preferences. The frontline staff and RD did not collaborate in the development and implementation of the resident's plan of care.

B) Resident #013 returned from the hospital on an identified date in March, 2014. A progress note made by the ADOC on an identified date in April, 2014, stated that the resident's Power of Attorney (POA) requested that the resident be reassessed by the RD due to a potential medical diagnosis while in the hospital. The progress note also stated that a referral was to be made to the RD by the ADOC. Interview with the RD on an identified date in June, 2014, confirmed a referral was never received. Interview with the ADOC and ED confirmed that the referral form could not be found. The ADOC did not collaborate with the RD regarding a dietary assessment as per POA request. (586)

2. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) Resident #019 reported that they were transferred improperly on an identified date in March, 2014 causing the resident to have pain. The home had a meeting with the resident and resident's POA and discussed a plan to ensure that this did not happen again as there had been previous concerns of improper transferring prior to this incident. They decided that they would send a referral to the physiotherapist, restorative care worker and the staff educator to provide further training to the staff on proper transferring of this resident. As of June 26, 2014 there had not been any further implementation, development or follow-up of the education to date as verified by the DOC.

B) Resident #050's plan of care stated that they are to avoid certain food products as per Speech Language Pathologist (SLP) recommendations. The resident's plan of care also stated that the resident is to receive these food items.
(506)

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

Sep 15, 2014(A1)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 care set out in the plan of care is provided to resident #053, #054, #006, #056, #013, #057, #058, #051, #050, #062, #063 and #064 as specified in the plan of care.

Grounds / Motifs :

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

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

A)Resident #053's plan of care and meal service report stated that the resident is to receive chocolate milk at meals. The resident did not receive chocolate milk during breakfast service on two identified dates in June, 2014, or during lunch service on an identified date in June, 2014. Resident #054's plan of care stated that the resident is to receive chocolate milk at breakfast and morning beverage pass. The resident did not receive chocolate milk at breakfast on two identified dates June, 2014.

B) Resident #006 and #056's plan of care and meal service reports stated that the residents are to have cream, butter, margarine or gravy added to their food. These residents did not have any cream, margarine, butter or gravy added to their food during lunch service on an identified date in June, 2014. The cook confirmed that none of these items were added to any of the residents' meals as special dietary interventions.

C) Resident #013's plan of care and meal service report stated that the resident is to receive 250 ml of their preferred juice at their meals. The resident did not receive their preferred juice at breakfast and lunch on an identified date in June, 2014, dinner on an identified date in June, 2014, and breakfast on an identified date in June,

2014.

D) Resident #057's plan of care and meal service report stated that the resident is to receive yogurt at breakfast. The resident did not receive yogurt during breakfast service on an identified date in June, 2014.

E) Resident #058's plan of care and meal service report stated that the resident is to receive crustless bread. During breakfast and lunch on an identified date in June, 2014, the resident received toast and bread with crusts. Resident #007's meal service report stated the resident is to receive crustless sandwiches only. During lunch on an identified date in June, 2014, the resident received a sandwich with crusts.

F) Resident #051's plan of care and snack service report stated that, the resident is to receive a muffin at morning beverage pass. The resident was not offered and did not receive a muffin during morning beverage pass on an identified date in June, 2014. There was no muffin on the beverage cart for the resident. This was confirmed by the PSW delivering the drinks and snacks.

G) Resident #050's plan of care stated that the resident is to receive their preferred juice, and yogurt at morning beverage pass as well as nutritional supplement. The resident was offered labelled juice during morning snack pass on an identified date in June, 2014, however was not offered and did not receive their preferred juice, yogurt, or their nutritional supplement. These items were not listed on the resident's snack service report that the staff are to refer to during beverage and snack pass. The PSW completing the morning beverage pass on an identified date in June, 2014, did not refer to the snack service report binder at all while performing this duty.

H) Resident #053, #062, #063 and #064's plans of care stated that they are to receive prune juice at breakfast. The residents did not receive prune juice during breakfast service on an identified date in June, 2014. (586)

2. 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 #013's plan of care directed staff to ensure that their specialized wheelchair cushion is applied properly. On two occasions as documented in the progress notes and confirmed by Registered staff on an identified date in May, 2014, and June, 2014 the specialized cushion was not applied appropriately. (506)

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

Sep 15, 2014(A1)

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

Order / Ordre :

The licensee shall ensure that the home is complying with their policies related to Admissions, Transfers, Discharges and Deaths, Weight Management Policy and Fall Intervention Risk Management.

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that their Weight Management Policy was complied with.

The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] stated that if a weight loss or gain is 2.0 kilograms (kg) or greater from the preceding month, a re-weigh is to be completed immediately. The following residents had weight changes greater than 2.0 kg in one month and re-weighs were not completed: resident #011 had a weight loss of 3.7 kg, resident #016 had a weight loss of 2.6 kg, resident #054 had a weight loss of 3.6 , and resident #061 has a weight loss of 8.4 kg. (586)

2. The licensee did not ensure that their Admission, Transfer and Discharges and Death Policy was complied with.

Resident #008 returned from the hospital on an identified date in May 2014 and did not have a Resident Assessment Instrument-Material Data Set (RAI-MDS) Significant Change in Condition Assessment completed despite having a change in physical status. Resident #008 also did not have a Head to Toe Assessment completed at the time of re-admission. Resident #021 also returned from the hospital on an identified date in May 2014 and did not have a Head to Toe Assessment completed at the time of re-admission. Policy #LTC-B-80 [Admissions, Transfers, Discharges and Death] revised August 2012 stated that appropriate assessments are to be completed by the Interdisciplinary Team. The Assessment Schedule stated that on re-admission from hospital, MDS 2.0 Significant Change in Condition are to be completed as well as a Head to Toe Assessment. This was confirmed on June 25, 2014 by the Assistant Director of Care . (536)

3. The licensee did not ensure that their Fall Policy was complied with.

The home's policy [Fall Interventions Risk Management (FIRM) Program, LTC-C-E-60 revised date March 2014] was complied with related to resident #005 and resident #008. The policy directed the staff to complete a Post Fall Action Checklist completed.
- Resident #005 had three falls; during the months of May and June, 2014 and no Post Fall Action Checklist for residents who have fallen.
-Resident #008 had a fall on an identified date in June, 2014 and no Post Fall Action Checklist completed.
- The DOC confirmed that the staff were not completing the checklist as per the home's policy. (506)

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

Sep 15, 2014(A1)

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2014_240506_0010, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that resident #004 receives immediate treatment and interventions for all skin tears.

The licensee shall ensure that resident #006 receives equipment, devices and positioning aides to relieve pressure and treat pressure ulcers.

The licensee shall ensure that resident #022 and #023 who are dependent on staff for repositioning are repositioned every two hours as required depending on their condition.

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that resident #004 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Observation of resident #004 on an identified date in June, 2014 noted that the resident had a skin tear on their body and another skin tear just below. While reviewing resident #004's plan of care, there was no documentation to indicate that the resident's skin tears received immediate treatment and interventions to promote healing. Interview with the RN and PSW on an identified date in June, 2014 confirmed that they were not aware of the skin tears that were observed on an identified date in June, 2014.

(506)

2. The licensee did not ensure that the equipment, devices and positioning aids referred to subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A) Resident #006 was identified as having a pressure area on an identified date in June, 2014. It was also noted that the resident had been identified as having a blackened area on an identified date in May, 2014. The resident's pressure ulcer is currently a stage X wound.
- Resident #006 was noted to have a large mass on an identified area. The resident was assessed to have moderate pain daily on an identified date on the April, 2014 MDS assessment and takes regular pain medication twice per day as well as narcotic analgesic when required. The resident also sustained an injury in April 2014, had not been eating well and spends most of their time in bed.
- During an interview with the "Wound Care Champion", they confirmed that the resident would benefit from a pressure relief surface, but indicated that there were none available at the home.
- During an interview with the DOC, it was confirmed that the home did not have a pressure relief surface that was available for use by resident #006 to manage pressure and pain.

(167)

3. The licensee did not ensure that a resident who was dependant on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #022 was observed seated in their broda chair on an identified date in June, 2014 from 1200 hours until 1600 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before lunch time.
B) Resident #023 was observed seated in their tilt wheelchair on an identified date in June, 2014 from 0930 hours until 1230 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before 0930 when the resident was gotten up for the day. According to the MDS quarterly assessment completed on an identified date in April, 2014, the resident's pressure ulcer rating (PURS) score was five, which indicated the resident was at risk for impaired skin integrity. (506)

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

Sep 01, 2014(A1)

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will;

1. Ensure that all foods and fluids are served at safe and palatable temperatures and,
2. Ensure all residents are provided with eating aides and assistive devices required to safely eat and drink as comfortable and independently as possible at meals. The plan is to be submitted to Long-Term Care Homes Inspector Jessica Paladino by August 15, 2014 at: Jessica.Paladino@ontario.ca

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

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

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's Cook's Meal Production Daily Temperature Record indicated that cold foods should be maintained at 4 degrees Celsius Temperatures were taken nearing the end of lunch service on an identified date in June, 2014. The regular ham salad sandwich was probed at 11.8 degrees Celsius, the pureed sandwich at 5.9 degrees Celsius, and the marinated vegetable salad at 6.2 degrees Celsius. (586)

2. Previously issued as a CO on November 2013.

The licensee did not ensure each resident was provided with eating aids and assistive devices to safely eat and drink as comfortable and independently as possible.

A) Resident #014's meal service report, which is used by staff to be kept aware of residents' specific needs during dining, stated that the resident needed assistive devices for their beverages at meals. The resident received their fluids in regular cups without assistive devices during breakfast and lunch service on an identified date in June, 2014.

B) Resident #064's meal service report stated that they are to receive an adaptive device for fluids. The resident received their fluids without a adaptive device during lunch service on an identified date in June, 2014.

C) Resident #050's plan of care and meal service report stated that the resident is to receive soup using an adaptive device as per SLP recommendations to support eating and swallowing. The resident received their soup in a bowl during lunch service on an identified date in June, 2014.

D) Resident #060's meal service report stated that the resident is to receive a adaptive device for beverages at meals. The resident received their fluids without an adaptive device during breakfast and lunch service on an identified date in June, 2014.

E) Resident #054's meal service report, and resident #050's plan of care and meal service report, stated that the residents are to receive lipped plates for all meals. The residents received regular plates during lunch service on an identified date in June, 2014. (586)

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

Sep 01, 2014(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 24 day of July 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LESLEY EDWARDS - (A1)

Service Area Office /
Bureau régional de services : Hamilton

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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Aug 25, 2014;	2014_240506_0016 (A2)	H-000739-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Please see amended Order #001 related to the floor care program. All reference to lighting levels was deleted. The requirement to submit a plan for lighting should have been under a separate Order. At this time, the Order for lighting cannot be added to the Order and Inspection Reports and will remain non-compliant with a Voluntary Plan of Compliance as layed out in the Inspection Report.

Issued on this 25 day of August 2014 (A2)

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

Health System Accountability and Performance Division
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Aug 25, 2014;	2014_240506_0016 (A2)	H-000739-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

BERNADETTE SUSNIK (120) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 17, 18, 19, 20 , 23, 24, 25, 26 and 27, 2014.

The following inspections were conducted concurrently with this inspection-Complaint Inspections log numbers; H-000537-14, H-000422-14, H-000536-14 and H-000488-14;Critical Incident Inspections log numbers-H-000660-14, H-000661-14 and H-000331-14 and Follow up Inspections were also conducted with this inspection; H-000724-14, H-000725-14, H-000726-14,H-000728-14, H-000729-14, H-000730-14, H-000731-14.

During the course of the inspection, the inspector(s) spoke with Provincial Director, Provincial Director Nursing Operations and Compliance, Executive Director (ED), Acting Executive Director, Director of Care (DOC), Associate Director of Care (ADOC), Food Service Manager, Acting Food Service Manager, Acting Director of Environmental Services, Lodge Director, Director of Recreation, Volunteers & Spiritual Care, Provincial Dietitian, Registered Dietitian (RD), Physiotherapist, Restorative Care worker, Registered nursing staff, Personal Support Workers (PSW), Housekeeping and laundry staff, dietary staff, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services provided on all home areas and reviewed relevant documents including, but not limited to: policies and procedures, meeting minutes, menus, recipes, staff files and health care records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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. 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee did not ensure that procedures developed for cleaning resident bedroom floors were implemented.

Vinyl flooring surfaces were observed to be dirty in appearance, with particles such as paint chips stuck or embedded in the floor in resident rooms 300, 301, 302, 304, 306, 308, 313, 312 over the course of the inspection. The same conditions were present in the same rooms during inspections conducted on November 14 and 19, 2013 and January 29 and 30, 2014. Non-compliance was issued for both visits.

The home's housekeepers reported that the floors were difficult to clean and that the day to day mopping was not successful in removing the ground in dirt or the embedded particles, regardless of the cleaning products available to them. The housekeepers reported that they have not used any floor machines in the bedrooms or have been given any new cleaning directions since the last inspection. The maintenance person was asked to demonstrate the effectiveness of their floor scrubbing machine in room 301. The machine was not able to remove all of the the embedded particles or the ground in dirt. However, if the machine were to be used several more times, with the appropriate products, it appeared possible that the floor conditions would improve.

The home's floor care policies and procedures were general in nature, describing the same routine for various different flooring types. In particular, policies #ES C-15-25, ES C-15-10, ES C-15-40 and ES C-15-20 were developed for floor care, describing that floor buffing was to be completed weekly or more often in high traffic areas. The maintenance records identified that the rooms identified above were all last buffed in May 2013. The floor care program for the vinyl flooring material in the above noted rooms has not been implemented. [s. 87. (2) (a)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the residents' plans of care set out clear directions to staff and others who provide direct care to the residents.

A) Resident #050's plan of care stated that they are to receive their preferred juice at the morning and the afternoon snack and yogurt at the morning snack and a half of a sandwich at the afternoon snack along with 125 ml nutritional supplement at morning snack, lunch and dinner. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, only listed that the resident is to receive 125 ml of assorted juices at snacks and a half of a sandwich at afternoon snack. It did not list their preferred juice, yogurt, or the nutritional supplement. During an observation of the morning beverage pass on an identified date in June, 2014, the resident was only offered juice or pop. The resident did not receive their preferred juice, yogurt or their nutritional supplement as per the resident's plan of care.

B) Resident #021's plan of care stated that staff are to encourage intake of snacks from snack cart due to the resident's weight loss, in addition to providing the resident

with a beverage and snack upon wakening. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, does not list any specific direction for staff regarding morning beverage pass. [s. 6. (1) (c)]

2. The licensee did not ensure that staff collaborated in the assessment, development and implementation of the residents' plans of care.

A) Resident #021's plan of care stated that the resident often sleeps in past breakfast so staff are to encourage food and beverage intake upon waking. During observation of morning beverage pass on an identified date in June, 2014, a staff member informed another staff member who was completing the snack pass that the resident enjoyed pudding and a banana every morning upon waking. The resident's snack service report and the plan of care did not list any of the resident's preferences. The frontline staff and RD did not collaborate in the development and implementation of the resident's plan of care.

B) Resident #013 returned from the hospital on an identified date in March, 2014. A progress note made by the ADOC on an identified date in April, 2014, stated that the resident's Power of Attorney (POA) requested that the resident be reassessed by the RD due to a potential medical diagnosis while in the hospital. The progress note also stated that a referral was to be made to the RD by the ADOC. Interview with the RD on an identified date in June, 2014, confirmed a referral was never received. Interview with the ADOC and ED confirmed that the referral form could not be found. The ADOC did not collaborate with the RD regarding a dietary assessment as per POA request. [s. 6. (4)]

3. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) Resident #019 reported that they were transferred improperly on an identified date in March, 2014 causing the resident to have pain. The home had a meeting with the resident and resident's POA and discussed a plan to ensure that this did not happen again as there had been previous concerns of improper transferring prior to this incident. They decided that they would send a referral to the physiotherapist, restorative care worker and the staff educator to provide further training to the staff on proper transferring of this resident. As of June 26, 2014 there had not been any

further implementation, development or follow-up of the education to date as verified by the DOC.

B) Resident #050's plan of care stated that they are to avoid certain food products as per Speech Language Pathologist (SLP) recommendations. The resident's plan of care also stated that the resident is to receive these food items. (586) [s. 6. (4) (b)]

4. 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 #013's plan of care directed staff to ensure that their specialized wheelchair cushion is applied properly. On two occasions as documented in the progress notes and confirmed by Registered staff on an identified date in May, 2014, and June, 2014 the specialized cushion was not applied appropriately. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in their nutrition plan of care.

A)Resident #053's plan of care and meal service report stated that the resident is to receive chocolate milk at meals. The resident did not receive chocolate milk during breakfast service on two identified dates in June, 2014, or during lunch service on an identified date in June, 2014. Resident #054's plan of care stated that the resident is to receive chocolate milk at breakfast and morning beverage pass. The resident did not receive chocolate milk at breakfast on two identified dates June, 2014.

B) Resident #006 and #056's plan of care and meal service reports stated that the residents are to have cream, butter, margarine or gravy added to their food. These residents did not have any cream, margarine, butter or gravy added to their food during lunch service on an identified date in June, 2014. The cook confirmed that none of these items were added to any of the residents' meals as special dietary interventions.

C) Resident #013's plan of care and meal service report stated that the resident is to receive 250 ml of their preferred juice at their meals. The resident did not receive their preferred juice at breakfast and lunch on an identified date in June, 2014, dinner on an identified date in June, 2014, and breakfast on an identified date in June, 2014.

D) Resident #057's plan of care and meal service report stated that the resident is to receive yogurt at breakfast. The resident did not receive yogurt during breakfast

service on an identified date in June, 2014.

E) Resident #058's plan of care and meal service report stated that the resident is to receive crustless bread. During breakfast and lunch on an identified date in June, 2014, the resident received toast and bread with crusts. Resident #007's meal service report stated the resident is to receive crustless sandwiches only. During lunch on an identified date in June, 2014, the resident received a sandwich with crusts.

F) Resident #051's plan of care and snack service report stated that, the resident is to receive a muffin at morning beverage pass. The resident was not offered and did not receive a muffin during morning beverage pass on an identified date in June, 2014. There was no muffin on the beverage cart for the resident. This was confirmed by the PSW delivering the drinks and snacks.

G) Resident #050's plan of care stated that the resident is to receive their preferred juice, and yogurt at morning beverage pass as well as nutritional supplement. The resident was offered labelled juice during morning snack pass on an identified date in June, 2014, however was not offered and did not receive their preferred juice, yogurt, or their nutritional supplement. These items were not listed on the resident's snack service report that the staff are to refer to during beverage and snack pass. The PSW completing the morning beverage pass on an identified date in June, 2014, did not refer to the snack service report binder at all while performing this duty.

H) Resident #053, #062, #063 and #064's plans of care stated that they are to receive prune juice at breakfast. The residents did not receive prune juice during breakfast service on an identified date in June, 2014. [s. 6. (7)]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002,003,004

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that their Admission, Transfer and Discharges and Death Policy was complied with.

Resident #008 returned from the hospital on an identified date in May 2014 and did not have a Resident Assessment Instrument-Material Data Set (RAI-MDS) Significant Change in Condition Assessment completed despite having a change in physical status. Resident #008 also did not have a Head to Toe Assessment completed at the time of re-admission. Resident #021 also returned from the hospital on an identified date in May 2014 and did not have a Head to Toe Assessment completed at the time of re-admission. Policy #LTC-B-80 [Admissions, Transfers, Discharges and Death] revised August 2012 stated that appropriate assessments are to be completed by the Interdisciplinary Team. The Assessment Schedule stated that on re-admission from hospital, MDS 2.0 Significant Change in Condition are to be completed as well as a Head to Toe Assessment. This was confirmed on June 25, 2014 by the ADOC. [s. 8. (1)]

2. The licensee did not ensure that their Weight Management Policy was complied with.

The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] stated that if a weight loss or gain is 2.0 kilograms (kg) or greater from the preceding month, a re-weigh is to be completed immediately. The following residents had weight changes greater than 2.0 kg in one month and re-weighs were not completed: resident #011 had a weight loss of 3.7 kg, resident #016 had a weight loss of 2.6 kg, resident #054 had a weight loss of 3.6, and resident #061 has a weight loss of 8.4 kg.

3. The licensee did not ensure that their Fall Policy was complied with.

The home's policy [Fall Interventions Risk Management (FIRM) Program, LTC-C-E-60 revised date March 2014] was complied with related to resident #005 and resident #008. The policy directed the staff to complete a Post Fall Action Checklist completed.
- Resident #005 had three falls; during the months of May and June, 2014 and no Post Fall Action Checklist for residents who have fallen.
-Resident #008 had a fall on an identified date in June, 2014 and no Post Fall Action Checklist completed.
- The DOC confirmed that the staff were not completing the checklist as per the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

WN #4: 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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that resident #004 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Observation of resident #004 on an identified date in June, 2014 noted that the resident had a skin tear on their body and another skin tear just below. While reviewing resident #004's plan of care, there was no documentation to indicate that the resident's skin tears received immediate treatment and interventions to promote healing. Interview with the RN and PSW on an identified date in June, 2014 confirmed that they were not aware of the skin tears that were observed on an

identified date in June, 2014. [s. 50. (2) (b) (ii)]

2. The licensee did not ensure that the equipment, devices and positioning aids referred to subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A) Resident #006 was identified as having a pressure area on an identified date in June, 2014. It was also noted that the resident had been identified as having a blackened area on an identified date in May, 2014. The resident's pressure ulcer is currently a stage X wound.
- Resident #006 was noted to have a large mass on an identified area. The resident was assessed to have moderate pain daily on an identified date on the April, 2014 MDS assessment and takes regular pain medication twice per day as well as narcotic analgesic when required. The resident also sustained an injury in April 2014, had not been eating well and spends most of their time in bed.
- During an interview with the "Wound Care Champion", they confirmed that the resident would benefit from a pressure relief surface, but indicated that there were none available at the home.
- During an interview with the DOC, it was confirmed that the home did not have a pressure relief surface that was available for use by resident #006 to manage pressure and pain. [s. 50. (2) (c)]

3. The licensee did not ensure that a resident who was dependant on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #022 was observed seated in their broda chair on an identified date in June, 2014 from 1200 hours until 1600 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before lunch time.
B) Resident #023 was observed seated in their tilt wheelchair on an identified date in June, 2014 from 0930 hours until 1230 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before 0930 when the resident was gotten up for the day. According to the MDS quarterly assessment completed on an identified date in April, 2014, the resident's pressure ulcer rating (PURS) score was five, which indicated the resident was at risk for impaired skin integrity. [s. 50. (2) (d)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. 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).

Findings/Faits saillants :

1. The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's Cook's Meal Production Daily Temperature Record indicated that cold foods should be maintained at 4 degree Celsius. Temperatures were taken nearing the end of lunch service on an identified date in June, 2014. The regular ham salad sandwich was probed at 11.8 degrees Celsius, the pureed sandwich at 5.9 degrees Celsius, and the marinated vegetable salad at 6.2 degrees Celsius. [s. 73. (1) 6.]

2. The licensee did not ensure each resident was provided with eating aids and assistive devices to safely eat and drink as comfortable and independently as possible.

A) Resident #014's meal service report, which is used by staff to be kept aware of residents' specific needs during dining, stated that the resident needed assistive devices for their beverages at meals. The resident received their fluids in regular cups without assistive devices during breakfast and lunch service on an identified date in June, 2014.

B) Resident #064's meal service report stated that they are to receive an adaptive device for fluids. The resident received their fluids without a adaptive device during lunch service on an identified date in June, 2014.

C) Resident #050's plan of care and meal service report stated that the resident is to receive soup using an adaptive device as per SLP recommendations to support eating and swallowing. The resident received their soup in a bowl during lunch service on an identified date in June, 2014.

D) Resident #060's meal service report stated that the resident is to receive a adaptive device for beverages at meals. The resident received their fluids without an adaptive device during breakfast and lunch service on an identified date in June, 2014.

E) Resident #054's meal service report, and resident #050's plan of care and meal service report, stated that the residents are to receive lipped plates for all meals. The residents received regular plates during lunch service on an identified date in June, 2014. [s. 73. (1) 9.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 007

WN #6: The Licensee has failed to comply with LTCHA, 2007, 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:
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. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
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).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
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).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
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. 2007, c. 8, s. 3 (1).

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 indep

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 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. The licensee did not ensure that the rights of residents were fully respected and promoted with respect to being given access to protected outdoor areas in order to enjoy outdoor activity.

The home established an outdoor area for resident use more than 10 years ago by having a deck and elevated boardwalk built on one side of the building, just outside the main lounge. At one time, residents were able to independently use the outdoor space and were able to manipulate the exit door, which had a crash bar. Over time, the home did not maintain the condition of the deck and boardwalk, creating safety issues preventing residents from using the space without supervision. In addition, as the mobility status of residents changed, the management of the home did not consider amending or replacing the door to the outdoor space with a door that could be used independently by residents in wheelchairs or walkers.

A family member raised concerns during a family council meeting in March 2014 indicating that they would like to have access to the outdoor space but could not as the door would automatically lock behind them when on the deck or was kept magnetically locked on the inside. Discussion with an activation staff member revealed that residents are escorted outside only when staff or family are available.

Reasons were due to the fact that the outdoor area was not secured in any way, with access to the main road and because of the poor maintenance of the deck and boardwalk. In response to the residents, the management staff stated that the door to the outside was a fire department requirement and that nothing could be done. No door alternatives were sought which would continue to meet fire department regulations, such as a door with an automatic door opening device and a magnetic release button on the outside to be able to regain entry. [s. 3. (1)]

2. The licensee did not ensure that resident #014 was protected from abuse by a co-resident.
-On an identified date in June, 2014, the home submitted a critical incident report related to a abuse that took place at the home involving resident #014 and #015. During a review of the progress notes for both residents, it was confirmed that resident #014 had been abused by resident #015.
- It was noted in the plan of care for resident #015 that they had a previous history of abuse towards female staff and co-residents. [s. 3. (1) 2.]

3. The licensee did not ensure that every resident had his or her choices respected.

During morning beverage pass on an identified date in June, 2014, two PSWs were discussing going to the kitchen to get a banana for resident #012 who likes to have one every day. Resident #052, who was right nearby, overhead this, and when asked if they wanted a drink or snack, stated that they wanted a banana. The PSW stated they did not have any bananas. When the resident requested one again, the PSW said they would just give the resident a drink because they knew they would take it. The PSW then said they were going to the kitchen to get a banana for the other resident. Resident #052 did not receive a banana as per their request. [s. 3. (1) 19.]

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 rights of residents are fully respected and promoted and residents have their choices respected. To ensure that all residents are protected from abuse by a co-resident, to be implemented voluntarily.

WN #7: 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 resident-staff communication and response system was not available in every area accessible by residents. An outdoor space immediately outside of the main lounge was identified to be used by residents and was not equipped with an activation station. [s. 17. (1) (e)]

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 and ensuring that a resident-staff communication response system available in every area accessible by residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee of the long-term care home did not ensure that the lighting requirements set out in the Table to this section were maintained.

Resident bathrooms and corridors were measured on March 5, 2013 and again during this inspection. Non-compliance was previously issued on March 15, 2013. Other areas of the home may also be deficient but were not tested.

-Random resident washrooms were measured with a hand held portable light meter on March 5, 2013 and June 25, 2014. Lights were turned on and allowed to burn until completely illuminated (approx. 5 minutes). The resident washrooms in the home all had lights mounted to the wall above the sink. These lights were shielded with a wood valence which prevented the room from being adequately illuminated. Depending on the age of the light bulbs, various washrooms produced different lux levels. Toilet areas were measured to be between 30-50 lux (above toilet seat), sink areas were adequate and measured between 300-600 lux and the centre of the rooms were between 40-100 lux. The minimum required level for the room is 215.28 lux.
-The lounge area directly in front of the nurse's station, which was a pass through area and also considered a corridor was illuminated with pot lights, which produced a cone of light down to the floor. The lights did not adequately illuminate the space. The illumination level below the bulbs was measured to be 400 lux and only 80-90 lux between each pot light. The pot lights were spaced 6 feet apart. The requirement is 215.28 of continuous consistent lighting.
-The corridors in the home were illuminated with fluorescent tubes, spaced 10-12 feet apart. The illumination level below several of the corridor ceiling fixtures was 600-800 lux and 50-70 lux between the light fixtures. The measurement was taken 36 inches above the floor or at waist height, with the light source in front of the meter. Resident bedroom doors were closed to minimize the amount of natural light coming from the windows in the bedrooms. The lighting level required is 215.28 lux of continuous consistent lighting.

Discussion held with the Administrator on June 24, 2014 revealed that no actions have been taken to date with respect to having the home lighting levels increased with the exception of having a new lighting fixture installed in one bathroom as a trial. [s. 18.]

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 meets the lighting requirements as set out in the table are maintained, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #016 was protected from abuse by a staff member.

On an identified date in May, 2014, the ED observed a staff member physically abusing resident #016. The staff member was noted to physically abuse the resident while providing care.
- Inspector #536 conducted a review of the training and education records for staff at the home and the staff member's employee file. It was noted that there were no records found to indicate that the accused staff member had received their mandatory annual prevention of abuse and neglect training. (536) [s. 19. (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 protected from abuse by anyone, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the pain management program at the home provided for strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids.

A) A review of the home's policy titled "Pain Management and Symptom Management – LTC-E-80 last revised August 2012" revealed that the policy did not include identification of non-pharmacological interventions, equipment, supplies, devices and assistive aids to assist residents with their pain management. The policy referred only to pain management with regards to analgesic administration.

B) Resident #006 was noted to have sustained an injury on an identified date in April 2014, had a large mass on the their body that was noted to be malignant and was causing pain, had a stage x pressure ulcer on an area of their body and two pressure ulcers on another identified area and was noted to remain in bed most of the day. The resident was noted to require regular use of narcotic and non-narcotic analgesia.
- The document that the home refers to as the care plan for resident #006 under "Alteration in Comfort: Pain" did not include identification of any non-pharmacological interventions to manage the resident's pain or to assist in their comfort. [s. 52. (1) 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 the home provides for strategies to manage pain, including non-pharmacological interventions, equipment, supplies, devices and assistive aids, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that strategies were developed and implemented to respond to resident #015's demonstration of a responsive behaviour towards female co-residents.

A) During a review of the progress notes in resident #015's health file, it was noted that resident #015 displayed responsive behaviours toward female residents and female staff.
- The progress notes indicated that resident #015 displayed responsive behaviours towards female staff on identified dates in September, November, December, 2013 and responsive behaviours towards female co-residents in December, 2013, March, and June, 2014.
- A review took place of the document that the home refers to as the care plan, that was confirmed by the Resident Assessment Instrument Co-ordinator to be the care plan in place to direct care when the incident occurred. The care plan did not address the resident's responsive behaviour towards female co-residents and only indicated responsive behaviours towards staff. This care plan was dated as last reviewed on an identified date in April, 2014.
- The only intervention that was in place on an identified date in April, 2014 care plan indicated for staff to document when the resident was inappropriate with female staff, divert the resident's attention and remind not to touch. The care plan does not address the risk to female co-residents at the home, nor were there interventions in place to prevent or mitigate those risks to female co-residents. [s. 53. (4) (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 strategies are developed and implemented for preventing responsive behaviours, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that the residents with the following weight changes are assessed, and that actions are taken and outcomes are evaluated;
1. A change of 5 per cent body weight, or more, over one month.

A) Resident #011's weight since admission decreased 6.3 per cent over one month. Review of the resident's clinical health records and interview with the RD on June 23, 2014, confirmed that the resident was not assessed for significant weight loss.

B) Resident #061's weight decreased 12.4 per cent over one month. Review of the resident's clinical health records on June 25, 2014, confirmed that the resident was not assessed for significant weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 with significant weight changes are evaluated, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee did not ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance for the following;

-Exterior areas of the home, specifically the deck and elevated wooden boardwalk located on the one side of the building to which residents have access. The deck and boardwalk were observed to be in a state of neglect, with rotten wood planks, loose posts, raised nails, rough surfaces and uneven boards. No plans were in place for any remedial maintenance at the time of inspection. No documentation was available for review with respect to when any routine and preventive inspections had been conducted.
-Interior doors, specifically resident bathroom doors. During the inspection, doors in #309, 316, 328, 415 were unable to close or had to be pushed with pressure to close or open. Several of the hinges appeared to have pulled away from the door frame. Twenty of the doors also had a small nickle-sized hole in the door which was caused by a door stop attached to the hinges. The door stops were ineffective. A door in room #320 had a large hole (3 cm by 12 cm) in the door. [s. 90. (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 there are schedules and procedures in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Medications were not stored in a medication cart that was secure and locked on an identified date in June, 2014.

A) On an identified date in June, 2014, the medication cart was left unattended and unlocked outside of the nurses station and the Registered staff had left to go down the hall to give another resident their medications. The inspector was able to open the drawers of the medication cart. The ADOC confirmed that the medication cart was left unlocked and unattended. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (1) Every licensee of a long-term care home shall ensure that a training and orientation program for the home is developed and implemented to provide the training and orientation required under sections 76 and 77 of the Act. O. Reg. 79/10, s. 216 (1).

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the training and orientation program at the home was implemented.

A) The home has a binder that is titled" Orientation and Staff Development Toolkit 2012" that sets out the home's policies and procedures related to education and training. The policies indicated the requirements of the program, including the tracking systems to be used to record attendance at the education sessions.
During a review of the records provided by the home related to orientation and training for 2013 and 2014, it was noted that there was no clear record related to what education was provided and which staff attended these education sessions.
- It was noted that the lead person for education and training was no longer available at the home to provide information related to this program. It was noted in the home's training manual that there was a spreadsheet that was to have been completed to identify statistics related to education provided and attendance. Staff and managers at the home were unable to provide this information and were not able to confirm that this tracking had been done.
- It was noted that the home was not able to produce any clear record keeping or tracking related to the training and orientation program at the home. [s. 216. (1)]

2. The licensee did not ensure that at least annually, the home's training and orientation program was evaluated and updated in accordance with evidence-based practices.

It was noted that the lead for the training and orientation program at the home was not available to interview during this inspection and staff and managers at the home were not able to produce any record of an evaluation having been completed as required. [s. 216. (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 a training and orientation program at the home is implemented and that the training and orientation program is evaluated, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in home`s infection prevention and control program related to hand hygiene.

On an identified date in June, 2014 a Registered Practical Nurse (RPN) was observed doing the morning medication administration for five residents. The nurse did not wash or sanitize their hands in between pouring and administering medications to residents. On the same day at the lunch medication administration, the same RPN was observed administering medication to seven residents and once again did not wash or sanitize their hands in between pouring and administering medications.
-On an identified date in June, 2014 at lunch service, a PSW was observed in the dining room serving soup with their thumb positioned inside the bowl. No hand washing was observed during distribution of the tray of soup. [s. 229. (4)]

2. During afternoon snack pass on an identified date in June, 2014, two PSWs were observed touching cookies with their bare hands and serving these to the residents. During morning beverage pass on an identified date in June, 2014, a PSW was observed playing with their hair, then continued serving residents without having washed their hands. [s. 229. (4)]

3. The licensee did not ensure that on every shift, resident's symptoms were recorded

and that immediate action was taken as required.

The home's infection control policy (IPC-J-10) titled "Infection Surveillance" dated February 2014 requires Registered staff to "assess and document symptoms in the resident's progress notes". In addition, the home's infection control policies require Registered staff to complete a form titled "Home Area Daily Infection Control Surveillance" (IPC-J-10-15 ON) on a daily basis. The data collected on the form is required to be analyzed by the home's infection control designate for trends and to prevent or mitigate possible outbreaks. However, during the course of the inspection, the home management staff were not able to produce the Home Area Daily Infection Control Surveillance form for the months of March or April 2014. The management was not able to demonstrate that they took immediate steps to mitigate or prevent the spread of any infections that may have been present during the months of March and April 2014.

On April 22, 2014, confirmation of a positive case of Influenza B was received by Public Health for a resident in the retirement home, which is connected to the long-term care home. An official outbreak of Influenza was declared on April 23, 2014 for both retirement and long term care. The management of the long-term care home began a respiratory line listing, identifying 8 residents who were already symptomatic by April 23, 2014. Outbreak control measures were instituted on April 23, 2014, whereby contact precautions were re-enforced, residents were offered anti-viral medication, group activities cancelled, families contacted and notices posted. No documentary evidence (i.e. Home Area Daily Infection Control Surveillance Form) was available to confirm that residents were being monitored for symptoms prior to the outbreak and measures instituted so that the spread of infection could be contained. During the inspection, the health care records for 2 out of the 8 affected residents were identified by registered staff to have flu-like symptoms on or before April 20, 2014. One resident was reported to have coughing and congestion on April 14, 2014 and often visited residents on the retirement home side. The resident was later identified to be positive with Influenza B. The other resident was diagnosed with shallow breathing on April 19, 2014 and was sent to hospital for advanced symptoms on April 21, 2014. The resident was also positively diagnosed with Influenza B. [s. 229. (5) (b)]

Additional Required Actions:

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

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not respond in writing within ten days of receiving Residents' Council advice related to concerns or recommendations.

A) There was no record to indicate that recommendations made by the council regarding dietary concerns were responded to in writing within ten days. The ED confirmed that the council was not responded to within the ten days. [s. 57. (2)]

WN #18: 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 did not ensure that the home's nutrition care and hydration programs include a weight monitoring system to measure and record with respect to each resident, height upon admission and annually thereafter.

The home did not ensure that resident's heights were taken annually as evidenced by review of the home's clinical records. This was confirmed by Registered and non-registered staff and the ED. The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] does not include the requirement to take the resident's heights annually. This was confirmed by the ED. [s. 68. (2) (e) (ii)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all food and fluids in the food production system were prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality.

The recipe for the pureed ham salad sandwich was not followed. The recipe stated that to prepare the pureed bread, the cook was to break bread into a baking pan, add milk and mix, then bake this in the oven for 15 minutes. The cook was then to melt margarine and stir this into the bread, cool it, and reheat prior to service. Interview with the cook on June 19, 2014, confirmed that to make the pureed sandwiches, they added ham salad filling, bread, and margarine into a food processor, and served cold. The cook confirmed that the recipe was not followed. [s. 72. (3) (a)]

WN #20: 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, (a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee did not ensure that policies were implemented related to reporting and locating of residents' lost clothing and personal items.

A) When asked for a copy of the home's policy related to handling of missing items of clothing and other articles, "Nova policy, ES D-20-30 dated as last reviewed January 2012" was provided. The policy indicated the following:
- All lost clothing concerns from family or visitors were to be brought to the attention of the Resident Services Co-ordinator (RSC).
- The missing item was to be recorded on the "Client Service Response Form or the "Missing Clothing Checklist" by the RSC.
- The nursing department was to search the home area and the laundry staff were to search the laundry area and report back to the RSC.
- The RSC was then to report the results back to the person who made the complaint.
- During interviews with nursing and laundry staff, it was confirmed that a different form is currently being used ("Missing Laundry/Article Form") and staff provided conflicting information related to how to use this form and to whom it should be submitted.
- There was no policy to support the use of this form.
- One staff member indicated that the form is filled in by nursing and then tacked to the cork board in the laundry area. This staff member indicated that if the missing article is found, the form is filled in indicating that the article was found and when and is placed in the laundry binder at the nurses station. If the article is not found the staff member did not know of any protocol to follow.
-There was no consistent approach to dealing with residents' lost clothing or missing articles. [s. 89. (1) (a) (iv)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an interdisciplinary team, which must include the Medical Director, the pharmacy service provider and a registered dietitian meets annually to evaluate the effectiveness of the medication management system in the home:

On June 25, 2014, review of the program evaluation on Medication Management identified that the Medical Director, pharmacy service provider and the RD were not involved in the annual evaluation of the medication management program. This was confirmed by the DOC on June 26, 2014. [s. 116. (1)]

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. 131. (2)	CO #006	2014_240506_0009	536
LTCHA, 2007 s. 15. (2)	CO #001	2014_189120_0007	120
O.Reg 79/10 s. 31. (3)	CO #002	2014_240506_0009	506
O.Reg 79/10 s. 52. (2)	CO #002	2014_240506_0010	167
LTCHA, 2007 s. 6. (7)	CO #002	2014_210169_0002	506
O.Reg 79/10 s. 73. (2)	CO #005	2014_240506_0009	586
O.Reg 79/10 s. 77. (1)	CO #001	2014_240506_0009	586

Issued on this 25 day of August 2014 (A2)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A2)

Inspection No. / No de l'inspection : 2014_240506_0016 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000739-14 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 25, 2014;(A2)

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

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

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)

Pursuant to / Aux termes de :

O.Reg 79/10, 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,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

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

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

(A2)
The licensee shall:

1. Have the vinyl flooring material (in rooms 300, 301, 302, 304, 306, 308, 313, 312) evaluated by a flooring specialist to determine appropriate cleaning solutions, equipment and frequency necessary to keep the floor clean (free of ground in dirt and stuck on particles)
2. Clean the flooring material as per the specialist's recommendations.
3. Update the home's floor care procedures as per the specialist's recommendations with respect to routines, chemicals and equipment necessary to clean the type of flooring materials in the home. The procedures shall be implemented.
4. Educate all housekeeping staff with respect to the expectations of cleaning different flooring material in the home and the updated floor care procedures.

To be complied with by August 15, 2014.

Grounds / Motifs :

1. The licensee did not ensure that procedures developed for cleaning resident bedroom floors were implemented.

Vinyl flooring surfaces were observed to be dirty in appearance, with particles such as paint chips stuck or embedded in the floor in resident rooms 300, 301, 302, 304, 306, 308, 313, 312 over the course of the inspection. The same conditions were present in the same rooms during inspections conducted on November 14 and 19, 2013 and January 29 and 30, 2014. Non-compliance was issued for both visits.

The home's housekeepers reported that the floors were difficult to clean and that the day to day mopping was not successful in removing the ground in dirt or the embedded particles, regardless of the cleaning products available to them. The housekeepers reported that they have not used any floor machines in the bedrooms or have been given any new cleaning directions since the last inspection. The maintenance person was asked to demonstrate the effectiveness of their floor scrubbing machine in room 301. The machine was not able to remove all of the the embedded particles or the ground in dirt. However, if the machine were to be used several more times, with the appropriate products, it appeared possible that the floor conditions would improve.

The home's floor care policies and procedures were general in nature, describing the same routine for various different flooring types. In particular, policies #ES C-15-25, ES C-15-10, ES C-15-40 and ES C-15-20 were developed for floor care, describing that floor buffing was to be completed weekly or more often in high traffic areas. The maintenance records identified that the rooms identified above were all last buffed in May 2013. The floor care program for the vinyl flooring material in the above noted rooms has not been implemented.
(120)

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

Aug 15, 2014

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_210169_0002, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all aspects of residents' #050 and #021's plans of care, including care plans and snack service reports, are clear and consistent, and are updated to include all dietary interventions, to provide clear direction to staff and others who provide direct care to the residents.

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

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

Grounds / Motifs :

1. Previously issued as a CO on March 2014.

The licensee did not ensure that the residents' plans of care set out clear directions to staff and others who provide direct care to the residents.

A) Resident #050's plan of care stated that they are to receive their preferred juice at the morning and the afternoon snack and yogurt at the morning snack and a half of a sandwich at the afternoon snack along with 125 ml nutritional supplement at morning snack, lunch and dinner. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, only listed that the resident is to receive 125 ml of assorted juices at snacks and a half of a sandwich at afternoon snack. It did not list their preferred juice, yogurt, or the nutritional supplement. During an observation of the morning beverage pass on an identified date in June, 2014, the resident was only offered juice or pop. The resident did not receive their preferred juice, yogurt or their nutritional supplement as per the resident's plan of care.

B) Resident #021's plan of care stated that staff are to encourage intake of snacks from snack cart due to the resident's weight loss, in addition to providing the resident with a beverage and snack upon wakening. The resident's snack service report, which the staff use during snack pass to be kept aware of the residents' special dietary needs and interventions, does not list any specific direction for staff regarding morning beverage pass. (586)

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

Sep 15, 2014(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the interdisciplinary team collaborate in the assessment, development and implementation of resident #021, #013, #019 and #050.

Grounds / Motifs :

1. Previously issued as a VPC on November 2013.

The licensee did not ensure that staff collaborated in the assessment, development and implementation of the residents' plans of care.

A) Resident #021's plan of care stated that the resident often sleeps in past breakfast so staff are to encourage food and beverage intake upon waking. During observation of morning beverage pass on an identified date in June, 2014, a staff member informed another staff member who was completing the snack pass that the resident enjoyed pudding and a banana every morning upon waking. The resident's snack service report and the plan of care did not list any of the resident's preferences. The frontline staff and RD did not collaborate in the development and implementation of the resident's plan of care.

B) Resident #013 returned from the hospital on an identified date in March, 2014. A progress note made by the ADOC on an identified date in April, 2014, stated that the resident's Power of Attorney (POA) requested that the resident be reassessed by the RD due to a potential medical diagnosis while in the hospital. The progress note also stated that a referral was to be made to the RD by the ADOC. Interview with the RD on an identified date in June, 2014, confirmed a referral was never received. Interview with the ADOC and ED confirmed that the referral form could not be found. The ADOC did not collaborate with the RD regarding a dietary assessment as per POA request. (586)

2. The licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

A) Resident #019 reported that they were transferred improperly on an identified date in March, 2014 causing the resident to have pain. The home had a meeting with the resident and resident's POA and discussed a plan to ensure that this did not happen again as there had been previous concerns of improper transferring prior to this incident. They decided that they would send a referral to the physiotherapist, restorative care worker and the staff educator to provide further training to the staff on proper transferring of this resident. As of June 26, 2014 there had not been any further implementation, development or follow-up of the education to date as verified by the DOC.

B) Resident #050's plan of care stated that they are to avoid certain food products as per Speech Language Pathologist (SLP) recommendations. The resident's plan of care also stated that the resident is to receive these food items.
(506)

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

Sep 15, 2014(A1)

Pursuant to / Aux termes de :

LTCHA, 2007, 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 care set out in the plan of care is provided to resident #053, #054, #006, #056, #013, #057, #058, #051, #050, #062, #063 and #064 as specified in the plan of care.

Grounds / Motifs :

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

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

A)Resident #053's plan of care and meal service report stated that the resident is to receive chocolate milk at meals. The resident did not receive chocolate milk during breakfast service on two identified dates in June, 2014, or during lunch service on an identified date in June, 2014. Resident #054's plan of care stated that the resident is to receive chocolate milk at breakfast and morning beverage pass. The resident did not receive chocolate milk at breakfast on two identified dates June, 2014.

B) Resident #006 and #056's plan of care and meal service reports stated that the residents are to have cream, butter, margarine or gravy added to their food. These residents did not have any cream, margarine, butter or gravy added to their food during lunch service on an identified date in June, 2014. The cook confirmed that none of these items were added to any of the residents' meals as special dietary interventions.

C) Resident #013's plan of care and meal service report stated that the resident is to receive 250 ml of their preferred juice at their meals. The resident did not receive their preferred juice at breakfast and lunch on an identified date in June, 2014, dinner on an identified date in June, 2014, and breakfast on an identified date in June,

2014.

D) Resident #057's plan of care and meal service report stated that the resident is to receive yogurt at breakfast. The resident did not receive yogurt during breakfast service on an identified date in June, 2014.

E) Resident #058's plan of care and meal service report stated that the resident is to receive crustless bread. During breakfast and lunch on an identified date in June, 2014, the resident received toast and bread with crusts. Resident #007's meal service report stated the resident is to receive crustless sandwiches only. During lunch on an identified date in June, 2014, the resident received a sandwich with crusts.

F) Resident #051's plan of care and snack service report stated that, the resident is to receive a muffin at morning beverage pass. The resident was not offered and did not receive a muffin during morning beverage pass on an identified date in June, 2014. There was no muffin on the beverage cart for the resident. This was confirmed by the PSW delivering the drinks and snacks.

G) Resident #050's plan of care stated that the resident is to receive their preferred juice, and yogurt at morning beverage pass as well as nutritional supplement. The resident was offered labelled juice during morning snack pass on an identified date in June, 2014, however was not offered and did not receive their preferred juice, yogurt, or their nutritional supplement. These items were not listed on the resident's snack service report that the staff are to refer to during beverage and snack pass. The PSW completing the morning beverage pass on an identified date in June, 2014, did not refer to the snack service report binder at all while performing this duty.

H) Resident #053, #062, #063 and #064's plans of care stated that they are to receive prune juice at breakfast. The residents did not receive prune juice during breakfast service on an identified date in June, 2014. (586)

2. 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 #013's plan of care directed staff to ensure that their specialized wheelchair cushion is applied properly. On two occasions as documented in the progress notes and confirmed by Registered staff on an identified date in May, 2014, and June, 2014 the specialized cushion was not applied appropriately. (506)

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

Sep 15, 2014(A1)

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

Order / Ordre :

The licensee shall ensure that the home is complying with their policies related to Admissions, Transfers, Discharges and Deaths, Weight Management Policy and Fall Intervention Risk Management.

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that their Weight Management Policy was complied with.

The home's policy [Nutritional Assessment and Care, Weight Management LTC-G-60, revised August 2012] stated that if a weight loss or gain is 2.0 kilograms (kg) or greater from the preceding month, a re-weigh is to be completed immediately. The following residents had weight changes greater than 2.0 kg in one month and re-weighs were not completed: resident #011 had a weight loss of 3.7 kg, resident #016 had a weight loss of 2.6 kg, resident #054 had a weight loss of 3.6 , and resident #061 has a weight loss of 8.4 kg. (586)

2. The licensee did not ensure that their Admission, Transfer and Discharges and Death Policy was complied with.

Resident #008 returned from the hospital on an identified date in May 2014 and did not have a Resident Assessment Instrument-Material Data Set (RAI-MDS) Significant Change in Condition Assessment completed despite having a change in physical status. Resident #008 also did not have a Head to Toe Assessment completed at the time of re-admission. Resident #021 also returned from the hospital on an identified date in May 2014 and did not have a Head to Toe Assessment completed at the time of re-admission. Policy #LTC-B-80 [Admissions, Transfers, Discharges and Death] revised August 2012 stated that appropriate assessments are to be completed by the Interdisciplinary Team. The Assessment Schedule stated that on re-admission from hospital, MDS 2.0 Significant Change in Condition are to be completed as well as a Head to Toe Assessment. This was confirmed on June 25, 2014 by the Assistant Director of Care . (536)

3. The licensee did not ensure that their Fall Policy was complied with.

The home's policy [Fall Interventions Risk Management (FIRM) Program, LTC-C-E-60 revised date March 2014] was complied with related to resident #005 and resident #008. The policy directed the staff to complete a Post Fall Action Checklist completed.
- Resident #005 had three falls; during the months of May and June, 2014 and no Post Fall Action Checklist for residents who have fallen.
-Resident #008 had a fall on an identified date in June, 2014 and no Post Fall Action Checklist completed.
- The DOC confirmed that the staff were not completing the checklist as per the home's policy. (506)

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

Sep 15, 2014(A1)

Order # /
Ordre no : 006

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

Linked to Existing Order /
Lien vers ordre existant: 2014_240506_0010, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that resident #004 receives immediate treatment and interventions for all skin tears.

The licensee shall ensure that resident #006 receives equipment, devices and positioning aides to relieve pressure and treat pressure ulcers.

The licensee shall ensure that resident #022 and #023 who are dependent on staff for repositioning are repositioned every two hours as required depending on their condition.

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that resident #004 who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

Observation of resident #004 on an identified date in June, 2014 noted that the resident had a skin tear on their body and another skin tear just below. While reviewing resident #004's plan of care, there was no documentation to indicate that the resident's skin tears received immediate treatment and interventions to promote healing. Interview with the RN and PSW on an identified date in June, 2014 confirmed that they were not aware of the skin tears that were observed on an identified date in June, 2014.

(506)

2. The licensee did not ensure that the equipment, devices and positioning aids referred to subsection (1) were readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A) Resident #006 was identified as having a pressure area on an identified date in June, 2014. It was also noted that the resident had been identified as having a blackened area on an identified date in May, 2014. The resident's pressure ulcer is currently a stage X wound.
- Resident #006 was noted to have a large mass on an identified area. The resident was assessed to have moderate pain daily on an identified date on the April, 2014 MDS assessment and takes regular pain medication twice per day as well as narcotic analgesic when required. The resident also sustained an injury in April 2014, had not been eating well and spends most of their time in bed.
- During an interview with the "Wound Care Champion", they confirmed that the resident would benefit from a pressure relief surface, but indicated that there were none available at the home.
- During an interview with the DOC, it was confirmed that the home did not have a pressure relief surface that was available for use by resident #006 to manage pressure and pain.

(167)

3. The licensee did not ensure that a resident who was dependant on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

A) Resident #022 was observed seated in their broda chair on an identified date in June, 2014 from 1200 hours until 1600 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before lunch time.
B) Resident #023 was observed seated in their tilt wheelchair on an identified date in June, 2014 from 0930 hours until 1230 hours. The resident was not repositioned in their chair during the observation period. The staff member assigned to this resident confirmed that the resident had not been repositioned in their chair since before 0930 when the resident was gotten up for the day. According to the MDS quarterly assessment completed on an identified date in April, 2014, the resident's pressure ulcer rating (PURS) score was five, which indicated the resident was at risk for impaired skin integrity. (506)

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

Sep 01, 2014(A1)

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
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.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home will;

1. Ensure that all foods and fluids are served at safe and palatable temperatures and,
2. Ensure all residents are provided with eating aides and assistive devices required to safely eat and drink as comfortable and independently as possible at meals. The plan is to be submitted to Long-Term Care Homes Inspector Jessica Paladino by August 15, 2014 at: Jessica.Paladino@ontario.ca

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

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

Grounds / Motifs :

1. Previously issued as a VPC on May 2014.

The licensee did not ensure that foods and fluids were being served at safe and palatable temperatures.

The home's Cook's Meal Production Daily Temperature Record indicated that cold foods should be maintained at 4 degrees Celsius Temperatures were taken nearing the end of lunch service on an identified date in June, 2014. The regular ham salad sandwich was probed at 11.8 degrees Celsius, the pureed sandwich at 5.9 degrees Celsius, and the marinated vegetable salad at 6.2 degrees Celsius. (586)

2. Previously issued as a CO on November 2013.

The licensee did not ensure each resident was provided with eating aids and assistive devices to safely eat and drink as comfortable and independently as possible.

A) Resident #014's meal service report, which is used by staff to be kept aware of residents' specific needs during dining, stated that the resident needed assistive devices for their beverages at meals. The resident received their fluids in regular cups without assistive devices during breakfast and lunch service on an identified date in June, 2014.

B) Resident #064's meal service report stated that they are to receive an adaptive device for fluids. The resident received their fluids without a adaptive device during lunch service on an identified date in June, 2014.

C) Resident #050's plan of care and meal service report stated that the resident is to receive soup using an adaptive device as per SLP recommendations to support eating and swallowing. The resident received their soup in a bowl during lunch service on an identified date in June, 2014.

D) Resident #060's meal service report stated that the resident is to receive a adaptive device for beverages at meals. The resident received their fluids without an adaptive device during breakfast and lunch service on an identified date in June, 2014.

E) Resident #054's meal service report, and resident #050's plan of care and meal service report, stated that the residents are to receive lipped plates for all meals. The residents received regular plates during lunch service on an identified date in June, 2014. (586)

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

Sep 01, 2014(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 25 day of August 2014 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK - (A2)

Service Area Office /
Bureau régional de services : Hamilton