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
Direction de l'amélioration de la performance et de la conformité

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 27, 2015	2015_405189_0006	T-1678-15	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

HUMBER VALLEY TERRACE
95 Humber College Blvd. Rexdale ON M9V 5B5

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

NICOLE RANGER (189), JULIET MANDERSON-GRAY (607), SARAN DANIEL-DODD (116), SHIHANA RUMZI (604)

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): April 8, 9,10,13,14,15,16, 20, 21, 22, 2015

The following Complaint inspections were conducted concurrently with this RQI:T-1130-14, T-1204-14, T-2084-15
The following Critical Incident inspections were conducted concurrently with this RQI: T-333-14, T-923-14, T943-14, T-1303-14, T-1532-14, T-2261-15

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care(DOC), Assistant Director of Care(ADOC), Resident Assessment Instrument Coordinator(RAI), social worker(SW), recreational manager, dietitian(RD), food service manager(FSM) wound care champion, Family Council President, Family Council Co-chair, Resident Council Co-chair, registered staff, personal support workers(PSW), residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.

19 WN(s)
8 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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:
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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be protected from abuse.

On July 21 2014, the licensee reported to the Director that on or around July 20, 2014, an identified PSW attempted to provide a shower to resident #012. Resident #012 was

uncooperative with the PSW. The PSW stated the following to resident #012 "you have no manners, I am not your mother, don't talk to me that way, you are rude". The PSW repeatedly called resident #012 "rude" during the shower and in the presence of another PSW.

Interviews held with the identified PSW, the DOC and ADOC confirmed that the allegations were founded and constituted as verbal abuse under the resident's bill of rights. The PSW was disciplined and provided with retraining on the licensee's non-abuse policy. [s. 3. (1) 2.]

2. The licensee has failed to ensure that every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On a specified date. the inspector was outside the hallway on an identified unit and observed resident #039 sitting on the toilet holding onto the wheelchair with the bathroom door open. The inspector approached an identified PSW about the privacy issues, and PSW began to laugh at resident. An interview with the identified PSW revealed that the bathroom door should have been closed and privacy was not provided to the resident.

An interview with the primary PSW for resident #039 confirmed that the bathroom door should have been closed and that privacy was not provided to the resident. [s. 3. (1) 8.]

3. The licensee has failed to ensure that every resident has the right to 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.

On a specified date, the inspector observed the Electronic Medication Administration Record (E-MAR) screen in a corridor on an identified unit left unattended, displaying 12 residents medication profile. An identified registered staff was observed down the hallway administering medication to a resident. The identified registered staff confirmed that the medication screen was unlocked and visible to anyone passing by and did not protect the residents' personal health information.

On a specified date, on an identified unit, it was noted the medication cart parked directly outside the sunroom showed confidential medication information for resident #031. Inspector remained with the medication cart and noted identified RPN coming out the bathroom. Inspector spoke with identified RPN who confirmed confidential medication information was visible.

Inspector spoke to the DOC who confirmed medication carts and E-MAR screens are to be locked as per homes policy when medication cart is not in use. [s. 3. (1) 11. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be protected from abuse; every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, and every resident 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, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

During an interview with the Infection Control Coordinator, the inspector was informed that two residents had ongoing positive results for an identified condition. The inspector interviewed the PSW's who were providing care to the residents' and they were unaware of the identified condition.

Upon review of the plan of care for resident #031 and #032 there was no reference to the identified condition. Interview with the registered staff confirmed the written plan of care did not identified the condition for both residents.

Interview with the Infection Control Program Coordinator confirmed both resident #031 and #032 plans of care were lacking information related to the condition, which is required for staff to know when providing care to the resident. [s. 6. (1) (c)]

2. The written plan of care for resident #017 states that the resident requires incontinence checks and changes due to total bladder/bowel incontinence and immobility. The resident is dependent on the staff for toileting.

On a specified date, the inspector observed resident #017 in his/her wheelchair from 10:00 a.m inclusive to 1:30 p.m. An interview with the assigned PSW confirmed that he/she did not conduct incontinence checks for the resident during this period. Interviews held with PSWs, registered staff and the DOC provided conflicting information surrounding the established frequency of incontinence checks for the resident.

The written plan of care does not set out clear directions on the established schedule for incontinence checks for resident #017. [s. 6. (1) (c)]

3. Review of the written plan of care for resident #017 indicates that the resident is at high risk for skin impairment related to incontinence, immobility and previous stage two pressure ulcer.

On a specified date, the inspector observed resident #017 to be seated on a therapeutic cushion that was covered. Interviews held with registered staff, PSW and the DOC revealed that the therapeutic cushion is not to be covered as it reduces the effectiveness

and intended purpose.

The written plan of care for resident #017 does not identify the use of the therapeutic cushion and/or directions for use to manage the resident's skin integrity. [s. 6. (1) (c)]

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

During an interview with resident #039, he/she reported to the inspector that the staff often transfer him/her without using a lift. Review of resident #039 plan of care revealed that resident should use a sit to stand lift for all transfers.

During an interview with an identified PSW by inspector 189 and inspector 607, the PSW confirmed that he/she often perform one person transfer of resident to and from the bathroom and in and out of bed without using a sit to stand lift.

Interview with a registered staff member confirmed that two staff member is to provide transfer to resident and resident is to use a sit to stand lift for all transfers. Interview with the ADOC and the DOC confirmed that the home's expectation is that staff will follow the resident's care plan. [s. 6. (7)]

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review for resident #005 revealed that he/she sustained a fracture and is to wear a splint.

A review of resident #005’s care plan did not identify the new diagnosis of a fracture or interventions on how staff is to provide care relating to the splint and fracture. Interview with a registered staff member confirmed that the care plan was not updated relating to resident #005’s fracture.

Interview with the ADOC and DOC confirmed that the home's expectation is that the plan of care is reviewed and revised at least every six months and at any other time when the resident’s care needs change. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, ensure that the care set out in the plan of care is provided to the resident as specified in the plan, and ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Findings/Faits saillants :

1. The licensee failed to ensure that resident #051 was protected from abuse by anyone and not neglected by the licensee or staff.

Resident and staff interviews revealed that during an identified night, resident #051 had an episode of vomiting in his/her room, when an identified PSW came into the room and observed the resident sitting up in his/her bed and emesis on the floor. Resident #051 reported that the identified PSW shouted at the resident and stated" why did you do this, I am not going to help you clean this up", and the identified PSW left the room without assisting the resident. Resident #051 reported that he/she had activated the call bell for assistance for the registered nurse to attend to him/her, when the identified PSW came back into the room and told the resident that the registered staff is on break and as the resident reported, the identified PSW still did not assist him/her to clean the emesis.

A review of video from the identified night, revealed that the identified PSW was observed entering resident #051 room on multiple occasions. On one occasion at 01:38am, the identified PSW was observed to bring in a fitted sheet into the room, and on another occasion at 04:49am, the identified PSW was observed to remove the fitted sheet out of the room.

The inspector interviewed resident #053, the roommate of resident #051. Resident #053 reported to the inspector that he/she heard the abusive incident between the identified PSW and resident #051, and the identified PSW "berated and yelled" at resident #051, and did not assist resident #051 in a timely manner. Resident #053 reported that he/she felt upset about the manner on how the identified PSW had spoken to resident #051.

Interview with the Executive Director (ED) confirmed that the home had initiated an investigation and that the incident did occur where resident #051 was not protected from abuse or neglected by anyone. [s. 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 residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The written plan of care for resident # 014 indicates that the resident requires support for bathing due to physical limitations. The plan of care indicates that the resident's scheduled shower days are Thursday and Sunday evenings. A review of the communication binder on the second floor documented that none of the residents received the scheduled shower on an identified date, due to staff shortage.

A review of the resident's bathing record for an identified month, revealed that resident #014 did not receive the minimum of two baths for an identified time period.

An interview with resident #014 confirmed that there are times when he/she will refuse a shower however, there have been several occasions where he/she has been requested by staff to reschedule his/her shower and it is not received.

Interviews with the DOC and ADOC confirmed that the second floor unit has experienced short staffing. In the event that there are staff shortages the expectation is that the residents affected receive a make up shower as well as the regular scheduled in the following week. Resident #014 did not receive the minimum of two showers per week for the identified weeks. [s. 33. (1)]

2. The written plan of care for resident # 019 indicates that the resident requires support for bathing due to physical limitations and decreased strength. The plan of care indicates the resident's scheduled shower days are Monday and Friday evenings. A review of the communication binder on the second floor documented that none of the residents received the scheduled shower on an identified date, due to staff shortage.

A review of the resident's bathing record for an identified months, revealed that the resident did not receive the minimum of two baths for an identified weeks.

Interviews with registered staff and PSWs confirmed that at times when the unit is short staffed they have been directed by management to reschedule showers.

Interviews with the DOC and ADOC confirmed that the second floor unit has experienced short staffing. In the event that there are staff shortages the expectation is that the residents affected receive a make up shower as well as the regular scheduled in the following week. Resident #019 did not receive the minimum of two showers per week for the identified weeks. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

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

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids served at a temperature that is both safe and palatable to the residents.

The licensee's policy entitled Food Temperature Standards (Index #LTC-H-420) revised September 2001, states that the temperature of all food items is taken just prior to a meal service and at point of meal service. Temperatures are recorded on the temperature chart at each meal by the dietary staff.

A review of the daily cook production temperature log and daily temperature record for the months of March and April 2015, revealed that cook production daily temperatures were not recorded for the following dates:
March 4 - no recorded temperatures for any planned meals
March 16- no recorded temperatures for breakfast
March 18- no recorded temperatures for breakfast and lunch

Food temperatures were not recorded on the following dates:
No temperatures recorded for all planned meals on March 7, 2015
No temperatures recorded for breakfast and lunch on March 3, 26, 28, 29, 2015
No temperatures recorded for March 6 and 8,2015 for dinner.

On a specified date, during the lunch meal service, resident #051 revealed to the inspector that the meal service is slow and the entree is often served cold. Interviews held with the Food Service Manger (FSM) confirmed that the temperatures are to be taken and recorded for all planned meals. [s. 73. (1) 6.]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.

The written plan of care for resident #013 documents that the resident requires support for eating or swallowing.

The written plan of care for resident #020 documents the resident requires support for eating or swallowing. The resident requires total assistance for all meals and beverages.

On a specified date, during the lunch meal service, the inspector observed that the resident #013 and resident #020 meals were plated and placed in front of them prior to a staff being available to provide assistance. Approximately 5 minutes after, two PSW's came over to provide the residents' with assistance. Interviews with the PSWs confirmed that residents that require assistance are to only be provided their meals once there is someone available to assist. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: Food and fluids being served at a temperature that is both safe and palatable to the residents, and that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

Record review and interview with the Resident Council Assistant revealed that residents were not consulted in the development of the survey in 2014.

An interview with the ED confirmed that the licensee did not seek the advice of Resident Council in the development and acting on the survey's results. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Interviews with the President of Family Council, Co-chair of Family Council and the Executive Director confirmed that the licensee did not seek the advice of the Family Council in developing and carrying out the satisfaction survey and in acting on its results. [s. 85. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee shall seek the advice of the Residents' Council and the Family Council in developing and carrying out the survey, and in acting on its results, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that 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.

On a specified date, the inspector observed pre-poured medication to be stored in white medication cups under a medication bin in an identified medication cart. An interview with the registered staff member assigned to the medication cart revealed that the medications were for three residents and all were controlled substances.

Interviews held with the registered staff member, DOC, ADOC and the ED confirmed that controlled substances are to remain in the separate locked area within the locked medication cart until administration. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #8: 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 has failed to ensure all staff participate in the implementation of the infection prevention and control program in the home.

During an interview with the Infection Control Coordinator (IPAC), the inspector was informed that two residents had ongoing positive results for an identified condition. The inspector interviewed the PSW and registered staff that were providing care to resident #031 on an identified unit, and they were unaware of the identified condition. A review of the unit daily infection surveillance record did not identify resident #031 as positive for the condition.

The inspector interviewed the PSW and registered staffs that were providing care to resident #032 on an identified unit, and they were unsure if isolation for resident #032 was due to being readmitted from hospital. The full-time RPN was unsure if resident #032 was positive.

Interview with the Infection Control Program Coordinator confirmed that staff were unaware of resident #031 and #032 as being positive for an identified condition. [s. 229. (4)]

2. On a specified date, during a review of a video that contained information for an identified date, the inspector observed multiple wheelchairs aligned in the hallway towards the wall. The inspector observed an identified PSW proceed to wipe four wheelchairs in a quick manner using one cavilon wipe.

Interview with the ADOC and DOC confirmed that the staff did not practice appropriate infection prevention and control technique when cleaning wheelchairs. [s. 229. (4)]

3. The licensee failed to ensure that on every shift, the symptoms are recorded and that immediate action is taken as required.

The licensee policy directs the staff to conduct specific treatment activities to manage the specified condition .

Record review of resident #031's laboratory results dated September 21st and September 23, 2014, revealed the resident continued to exhibit positive laboratory results.

Upon review of laboratory tests, there were no further tests taken after September 18, 2014. Interview with Infection Control coordinator confirmed there was no follow-up lab work done for resident #031 . [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 all staff participate in the implementation of the program and that on every shift, the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Record review for resident #005 revealed that he/she had multiple un-witnessed falls in March 2015.

A review of the licensee's policy entitled Interprofessional Clinical Programs, Fall Interventions Risk Management Program, Policy #LTC-E-60 Revised March 2014, revealed if a fall is not witnessed or the resident has hit their head, a neurological assessment will be initiated.

A review of resident #005's clinical record could not locate records that a neurological assessment was done for the falls in March 2015.

Interview with a registered staff member confirmed that neurological assessment for resident #005 was not done and could not be located [s. 8. (1) (a),s. 8. (1) (b)]

2. Record review for resident #004 revealed that he/she had an un-witnessed fall in March 2015.

A review of resident #004 clinical record could not locate records that a neurological assessment with a head injury routine was done for the fall in March 2015.

An interview with the registered staff member confirmed that neurological assessment for resident #004 was not done and could not be located [s. 8. (1) (a),s. 8. (1) (b)]

3. During an interview with resident #001 on a specified date, the resident identified that he/she had lost a bottle of shampoo two weeks prior. Resident stated he/she reported the missing shampoo to the day RN.

A review of the licensee's policy entitled Management of Concerns/Complaints/Compliments INDEX:LP-B-20, revealed that if concerns cannot be resolved immediately at point-of-service, the individual who is first aware of a concern will initiate the CSR form. A copy of the from as it is initially completed will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern.

Record review for resident #001, the inspector was unable to find progress notes or CSR (Customer Service Response) completed for the resident.

Interview with the identified RN confirmed that the resident had reported the missing item but he/she did not complete an client service compliant(CSC)report or document this information in the residents progress note.

During an family interview for resident #013 on a specified date, the POA identified that the resident had lost a gold hoop earrings with a hanging ruby stone which was given to the resident as a Christmas gift in 2013. The POA stated that he/she informed the RPN on the evening shift of the missing earrings.

Record review for resident #013, the inspector was unable to find progress notes or CSR (Customer Service Response) completed for the resident.

Interview with the Assistant Director of Care (ADOC) and review of the homes Customer Service Response binder for 2013-March 2015, confirmed that a CSR form for resident #013 was not completed. [s. 8. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

The inspector observed resident #005's call bell behind the bed and not within reach and accessible on the following dates: April 13, 2015 at 2:09pm, April 14, 2015 at 10:33am and April 14, 2015 at 3:03 p.m.

A review of the resident #005's plan of care updated February 18, 2015 revealed that call bell cord should be within reach.

Interview with an identified PSW on April 14, 2015 revealed that resident #005's call bell was behind the bed and was not within reach. Interview with an identified registered staff member revealed that the expectation is resident #005 call bell should be clipped to residents pillow. Interview with the ADOC revealed that the home's expectation is that resident call bell must be within reach and accessible at all times [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

Record review of the home's complaints binder revealed that on December 22, 2014, a written complaint was received by the home regarding concerns with housekeeping in an identified resident's room. A response was not sent to the complainant until January 10, 2015.

Record review revealed that on December 10, 2014, a written complaint was received by the home regarding concerns of missing items and meal services . A response was not sent to the complainant until December 28, 2014.

Interview with the ED confirmed that a response was not provided in writing to the complainants, and the Director was not notified in the required time frame. [s. 22. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

On January 30, 2014, a family member raised concern during a Family Council meeting that he/she had witnessed a staff member to be verbally rude and had pushed a resident. A Family Council concern form was completed by the Resident Service Coordinator (RSC) on January 30, 2014 to be forwarded to the ED for review. On February 14, 2014, the ED received the Family Council concern form from the RSC. The ED reported that the RSC did not remember to give the concern form to the Executive Director prior to this date. An investigation was conducted, and the MOHLTC was notified on February 14, 2015. The RSC staff member did not immediately report the suspicion of abuse or neglect of a resident that resulted in harm or risk of harm to the resident, and information upon which it is based to the Director. [s. 24. (1) 2.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home.

Interviews with registered and PSW staff indicated there is a language barrier with resident #029 who does not speak English and it is difficult to assess resident's aspects of care.

Staff indicated they wait for the Power Of Attorney (POA) to arrive to assist resident #029. When POA arrives medication and care is provided with translation and resident is calm with care.

When inspector asked what strategies are in place to communicate to the resident, staff indicated that they utilize a resident on another floor who speaks the specified language to communicate with the resident but this is not always successful, and no further strategies are developed to communicate with the resident. [s. 43.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review for resident #005 revealed that he/she had multiple falls in March 2015. A review of the home's policy entitled Interprofessional Clinical Programs, Fall Interventions Risk Management Program - Documentation/Monitoring,LTC-E-60, revised March 2014, revealed post fall documentation is to be completed after a resident has fallen.

Interview with a registered staff member confirmed that the post fall assessments were not completed for the resident falls in March 2015. Interview with the DOC and ADOC confirmed that post fall assessment are to be completed after every fall. [s. 49. (2)]

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

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(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 has failed to ensure that the resident who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load.

The written plan of care for resident #017 indicates the resident requires extensive assistance for bed mobility with two staff and is to be repositioned every two hours to decrease complications related to immobilty and skin breakdown.

On a specified date, the inspector observed the resident in his/her wheelchair from 10:00 a.m inclusive to 1:30 p.m. Interview with the assigned PSW states that he/she was aware of the resident's repositioning schedule. The PSW confirmed that he/she did not reposition the resident as required. Interview with the DOC confirmed that all residents are to be repositioned based on the assessed need. [s. 50. (2) (d)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

On January 30, 2014, a family member raised concern during a Family Council meeting that he/she had witnessed a staff member to be verbally rude and had pushed a resident. A Family Council concern form was completed by the Resident Service Coordinator (RSC) on January 30, 2014, to be forwarded to the ED for review. On February 14, 2014, the ED received the Family Council concern form from the RSC. The ED reported that the RSC did not remember to give the concern form to the Executive Director prior to this date. An investigation was conducted, however during an interview with the President of the Family Council and Executive Director, they confirmed that the licensee did not respond in writing within 10 days of receiving Family council advice related to the concern. [s. 60. (2)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of housekeeping, procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

On April 9, 2015, the inspector observed two identified residents wheelchairs to be visibly soiled. The wheelchair for one resident was scheduled to be cleaned on April 10, 2015, and the wheelchair for the other resident was scheduled to be cleaned on April 13, 2015. The inspector observed the two identified residents' wheelchair for a period of five days from April 9 to 15, 2015, on which the wheelchairs continued to be in the same manner and visibly soiled.

Staff interviews revealed that the wheelchairs are cleaned on the residents' shower days by the night staff, and the home's process is to take the wheelchairs to the shower room for a steam cleaning.

Interview and observations of the two identified wheelchairs by the DOC on April 15, 2015, confirmed that the identified wheelchairs are visibly soiled and does not appear to be cleaned by the staff. [s. 87. (2) (b)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: The complaint shall be investigated and resolved where possible,

and a response shall be made to the person who made the complaint, indicating what the licensee has done to resolve the complaint or that the licensee believes the compliant to be unfounded and the reasons for the belief, provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Record review of the home's complaints binder revealed that on December 22, 2014, a written complaint was received by the home regarding concerns with housekeeping in an identified resident's room. A response was not sent to the complainant until January 10, 2015.

Record review revealed that on December 10, 2014, a written complaint was received by the home regarding concerns of missing items and meal services . A response was not sent to the complainant until December 28, 2014.

Interview with the ED confirmed that a response was not provided in writing to the complainants within 10 business days. [s. 101. (1) 1.]

2. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

Record review revealed that on December 22, 2014, a written complaint was received by the home regarding concerns with housekeeping in an identified resident's room. A response was not sent to the complainant until January 10, 2015.

Record review revealed that on December 10, 2014, a complaint was received by the home regarding concerns of missing items and meal services. A response was not sent to the complainant until December 28, 2014.

An interview with the ED confirmed that the complainants were not given acknowledgment that their complaints could not be resolved within 10 business days or an expected resolution date. [s. 101. (1) 2.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On a specified date, the inspector observed pre-poured medication to be stored in white medication cups under a medication bin in an identified medication cart.

An interview with the registered staff member assigned to the medication cart revealed that the medications were for resident #021, resident #022 and resident #023. Two of the pills were Tylenol #3 and the other pill was Morphine.

An interview with the registered staff member confirmed that all controlled substances are to remain in the double-locked drawer until administration. Interviews with the registered staff member, DOC, ADOC and the administrator confirmed that all drugs are to remain in the original package until administered to a resident. [s. 126.]

Issued on this 7th day of July, 2015

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

Original report signed by the inspector.