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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 16, 2016	2016_431527_0007	004489-16	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

KATHLEEN MILLAR (527), HEATHER PRESTON (640), MICHELLE WARRENER (107), YVONNE WALTON (169)

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): March 10, 11, 14, 15, 16, 17, 21, 22, 24, 29, 30, 31, and April 1, 4, 5, 6, 7, 2016

The following inspections were completed concurrently with this Resident Quality Inspection (RQI):

Complaint inspections:

Log #004035-14 - pest control and menu planning issues
Log #004110-14 - premature discharge
Log #005448-15 - improper care
Log #011587-15 - medication issues
Log #013279-15 - staffing and assistance with feeding issues
Log #028649-15 - staffing, 24 hour registered nurse and bathing issues
Log #031813-15 - privacy issues
Log #033583-15 - improper care issues
Log #009003-16 - dietary, continence care and other issues

Log # 036280-15 was inspected concurrently with the RQI; however thee was a separate report completed for the Complaint inspection.

Critical Incident inspections:
Log #000524-14 - alleged abuse
Log #002785-14 - alleged abuse
Log #003503-14 - alleged abuse
Log #031114-15 - alleged abuse and/or neglect
Log #015852-15 - resident to resident abuse
Log #017059-15 - alleged staff to resident neglect
Log #018251-15 - alleged staff to resident abuse
Log #018417-15 - fall
Log #018781-15 - fall
Log #021879-15 - alleged staff to resident abuse
Log #025656-15 - alleged staff to resident abuse
Log #029994-15 - fall
Log #030874-15 - alleged staff to resident abuse
Log #031112-15 - improper care issues
Log #031343-15 - alleged staff to resident abuse
Log #035721-15 - attempted suicide
Log #004024-16 - personal health information breach
Log #007712-16 - alleged staff to resident abuse
Log #008580-16 - alleged staff to resident abuse
Log #005272-16 - alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with residents, family members of residents, President of the Residents` Council, the President and Vice President of the Family Council, Executive Director (ED), Director of Care (DOC),

Associate Director of Care (ADOC), physician, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), Manager of Dietary, Registered Dietitian (RD), cook, dietary aides, environmental aides, laundry aides, Program Manager, Program aides, volunteer, Environmental and Maintenance Manager, staff educator, wound and skin care lead, continence care lead, Behavioural Support Officer (BSO), Office Manager, Physiotherapist (PT), and physiotherapy assistant (PTA)

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

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

24 WN(s)
12 VPC(s)
7 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 O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

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

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).

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,
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system provided for the preparation of all menu items according to the planned menu at the lunch meals three specific dates in March 2016, and a dinner meal in April 2016, resulting in reduced variety, quality, and nutritive value.

In March 2016, the planned menu required tuna salad on a croissant with mixed green salad or vegetable stew with cauliflower and a corn muffin. The planned menu items were not prepared and available for residents requiring texture modified menus (minced and pureed texture). Mashed turnip was prepared instead of minced cauliflower; pureed

zucchini with parsley was prepared instead of pureed cauliflower; and mashed potatoes and gravy were prepared instead of a pureed corn muffin. Cook #157, who prepared the meal, confirmed that the vegetable substitutions were made due to insufficient quantities of cauliflower; however, it was not clear why the other substitutions were made.

On another day in March 2016, the planned menu required a pulled beef sandwich for residents receiving a pureed diet texture. Mashed potatoes were substituted for the pureed bread/bun at the observed meal. Dietary Aide #156 stated that the home routinely substituted mashed potatoes for bread for the pureed texture menu; however, they were unsure why the substitution was made.

In March 2016, the planned menu required a pureed Cobb salad (lettuce, spinach, green peppers, chicken, tomato, egg, salad dressing) with pureed bread. Substitutions were made for the pureed texture menu and staff prepared a hot pureed chicken with gravy, pureed zucchini with parsley (also substituted on another day in March 2016), and mashed potatoes with gravy. Pureed bread was not offered with the hot meal. Dietary aide #151 stated that a hot meal was prepared instead of the cold salad plate as not all residents would eat cold meals. The substitutions were not documented on the production sheets and had not been approved by the Registered Dietitian (RD).

The planned renal menu required a renal vegetable salad marinated (recipe contained carrots, cauliflower and Italian salad dressing); however, this was not prepared or offered for the renal menu. In March 2016, resident #048 voiced concerns to the LTC Inspector about routinely being offered foods that were not on the resident's planned renal menu. Dietary aide #151 confirmed that the renal vegetable salad was not prepared as per the planned menu.

In March 2016, the RD stated that staff were expected to prepare the planned menus as written and confirmed that she had not approved the menu substitutions.

On a specific day in April 2016, the planned menu required a creme brule tart; however, residents requiring a regular texture menu were offered white cake instead of the creme brule tart. The creme brule tarts were not available as per the planned menu. [s. 72. (2) (d)]

2. The licensee failed to ensure that menu substitutions were comparable to the planned menu at the observed lunch meals on three specific dates in March 2016.

On a specific date in March 2016, the planned pureed menu required a pureed corn muffin to be served with the hot entree choice (Vegetarian stew). The dietary aides #159 and #164 confirmed that pureed corn muffin was not prepared and available as per the planned menu and that mashed potatoes and gravy were substituted for the pureed muffin. Mashed potatoes with gravy was not a comparable substitution for a pureed muffin (different food group, different nutrient profile).

On another date in March 2016, the planned pureed menu required a pureed beef sandwich. Mashed potatoes and gravy were substituted for the bread in the beef sandwich. Dietary aide #156 confirmed that the home routinely/ substituted mashed potatoes for pureed bread at meals. The substitution was not comparable to the planned menu (different food group, different nutrient profile).

In March 2016, the planned pureed texture menu required a cold salad plate including chicken, lettuce/tomatoes/green peppers, egg, and bread. Staff substituted a hot entree (chicken, zucchini, and mashed potatoes) for the cold salad plate. The items were not comparable in taste (one was hot and the other cold) and mashed potatoes were substituted for the bread, which was not a comparable substitution.

In March 2016, the RD confirmed that staff were to follow the planned menu and that the substitutions had not been approved by the RD. [s. 72. (2) (e)]

3. The licensee failed to ensure that all menu substitutions were communicated to residents and staff at the observed lunch meals two days in March 2016, and the dinner meal in April 2016.

On a specific date in March 2016, mashed turnip was substituted for minced cauliflower, pureed zucchini was substituted for pureed cauliflower, mashed potatoes were substituted for pureed corn muffin, and bread was substituted for a croissant for the minced texture tuna sandwich. The substitutions were not communicated to residents or staff when the residents were asked their meal preference and the posted menus did not reflect the menu substitutions. Dietary aide #164 serving the meal was unable to identify what the pureed vegetable was without the LTC Inspector speaking to the cook #157 who prepared the meal. Residents' Council meeting minutes from January 2016, also reflected concerns from residents that the PSW staff do not know what is on the menu when they come to offer choices at the tables.

In March 2016, resident #048 voiced concerns to the LTC Inspector about routinely being

offered foods that were not on the resident's planned renal menu. Dietary aide #151 confirmed that staff used the regular menu demonstration plates to offer the resident meal choice. The dietary aide stated that they then make the substitutions in the kitchen based on the resident's menu requirements. The substitutions required on the resident's renal menu were not communicated to the resident when they were obtaining meal choices resulting in the resident voicing concerns to the LTC Inspector.

In April 2016, the planned menu required creme brule tarts; however, residents were provided white cake as a substitution. The posted menu was not revised to reflect the menu changes and the change was not communicated to residents. [s. 72. (2) (f)]

4. The licensee failed to ensure that all food was prepared and served using methods that preserved taste, nutritive value, appearance and food quality at the lunch meals on March 10, 11, and 16, 2016 and the dinner meal April 5, 2016.

On another day in March 2016, vegetable stew was served on a plate with a corn muffin and cauliflower. The stew was running into all the items on the plate and was difficult for some residents to eat on the plate. Resident #013 and #041 voiced concerns to the LTC Inspector about the visual appeal of the meal and serving the stew on a plate instead of a bowl.

Portion sizes offered to residents in March 2016, were less than the portions identified on the therapeutic extension menu resulting in reduced nutritive value of the meal. The planned menu required 250 millilitres (ml) of mixed green salad, staff served an approximate serving of 125 ml; a #6 scoop or 6 oz serving of vegetarian stew was required for all diet textures (regular, minced, pureed) and staff served a 3 ounce (oz) portion for all diet textures; a #8 scoop (4 oz portion) of cauliflower was required, staff served a 3 oz portion. Dietary aide #164 confirmed the portion sizes offered to residents with the LTC Inspector.

In March 2016, one portion of the pureed texture alternative meal (pureed egg salad sandwich and pureed spinach salad) was available for service on the second floor. The meal had been pre-portioned into a divided plate which was covered in saran wrap and sitting sideways on the food cart. The pureed spinach salad had run into the section with the pureed sandwich and over the side of the plate. The presentation and appearance of the meal was reduced.

In March 2016, recipes were not consistently followed by staff preparing the meal,

resulting in reduced taste, appearance, nutritive value and quality. The planned spinach salad required fresh green onions, iceberg lettuce, spinach, crisp bacon and ranch salad dressing; however, the salad served to residents contained only spinach and French salad dressing. The planned Cobb salad recipe required iceberg lettuce, romaine lettuce, spinach, green leaf lettuce, diced chicken, julienne green peppers, 1/4 of a tomato, 1/2 an egg and French salad dressing. The Cobb salad offered to residents contained iceberg lettuce, diced chicken, 1 slice of tomato, 2 slices of cucumber, 1/2 an egg with a multigrain roll (unbuttered).

In March 2016, the RD stated that staff were to follow the planned menu as written and confirmed that they had not approved the menu substitutions.

In April 2016, staff provided only one nosey and sippy cup for residents that required the assistive devices (resident #069, #072). Staff placed milk into the cup and then apple juice during the meal service while assisting resident #072, resulting in reduced taste and appearance of the meal (may curdle). Residents would have to finish all of the one fluid prior to the next fluid being placed into the cup and would not be able to drink different fluids throughout the meal. The Dietary Manager #103 confirmed that staff were to provide three separate devices at meals for residents who required sippy or nosey cups. [s. 72. (3) (a)]

5. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

Staff were not routinely monitoring the temperature of the "Indian menu" prior to service to residents. Temperatures were not monitored for the supper meal on any date between the beginning of March to the first week in April 2016. Dietary Aide #157 confirmed that the food temperatures were to be monitored prior to service and recorded in the "Indian Food Temperature Log" book. The dietary aide confirmed that food temperature records were not available and not recorded elsewhere for those dates. During interview, both Dietary Managers confirmed that staff were required to monitor and record food temperatures prior to service of the meal.

Food temperature monitoring records were also not recorded for the lunch and breakfast meals on specific dates in April 2016, for the traditional menu.

Staff did not ensure that food temperatures were monitored to ensure the prevention of

food borne illness. [s. 72. (3) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the food production system must, at a minimum, provide for, (e) menu substitutions that are comparable to the planned menu; and (f) communication to residents and staff of any menu substitutions. The licensee is also requested to 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, to be implemented voluntarily.

WN #2: 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 failed to ensure that residents were protected from abuse by anyone in the home.

A) On a specific date in July 2014, resident #053 was being fed their breakfast and the PSW that was feeding the resident, was observed forcibly pushing the resident's hand into their mouth and directing the resident to lick them. When another staff member called out to ask the PSW to stop, the PSW did not and continued to push the resident`s hand/fingers into their mouth and directing the resident to lick them. The resident was at high nutritional risk and was followed by a speech language pathologist for swallowing issues. The plan of care revealed the resident required total feeding assistance due to physical limitations and swallowing difficulties. The resident was cognitively impaired and was incapable of following verbal directions. The employee had been terminated, therefore was not interviewed, however the Executive Director (ED) and Director of Care (DOC) confirmed the incident occurred. (169)

B) On a specific date in July 2015, resident #059 was told by a PSW that they should put themselves on the toilet. The PSW then proceeded to provide care to the resident and the resident described the care as being rough. The resident was no longer at the home for an interview, however the Executive Director and Director of Care were able to confirm the incident occurred. The plan of care directed staff to provide the assistance of one PSW at all times for care. The documentation and interview with the ED and DOC confirmed the incident occurred. (169)

C) On a specific date in March 2016, resident #020 was offered a can of gingerale by PSW #120 during the evening snack. The resident tucked the gingerale down the side of their wheelchair. PSW #142 approached the resident and forcibly took the can of gingerale from the resident's wheelchair while the resident was holding the can. The resident was upset, tearful and their hand was hurting after the incident. The resident was cognitive, was able to communicate their needs and participated in decision making regarding their own care. Resident #073 witnessed PSW #142 yelling at resident #020 to give back the gingerale. Resident #073 also witnessed the PSW forcing the can of gingerale from resident #020's fingers and then pushed their hand away. Based on the home's investigation and a review of the home's videotape of the incident in March 2016, the employee was disciplined for abusing resident #020. The Executive Director and the DOC confirmed the incident occurred and confirmed that PSW #142 was disciplined. [s. 19. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that measures were in place to prevent the transmission of infections.

On two specific dates in March 2016, resident #034's medical equipment was observed sitting on the sink counter of a shared resident room with black mold in it. Resident #034 had a medical condition which required a specialized device and equipment. Both residents in the room use the sink and the equipment was not stored in a way to prevent the transmission of infection. The staff confirmed the medical equipment was not stored in a manner to prevent the transmission of infection, nor was the equipment clean and sanitary. The registered staff identified that the medical equipment with black mold in it was applied to the resident's specialized device, it would generate airborne mold spores throughout the shared room allowing for the transmission of infection toward the room mate and staff. This was confirmed by the registered nursing staff. [s. 86. (2) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of resident #064's continence, including bladder and bowel elimination.

In April 2016, an observation was made of resident #064`s urinary collection device. The clinical record was reviewed and indicated the Registered Dietician (RD) was monitoring the resident`s laboratory values and was unaware of any issues. The physician made a clinical notation in September 2015 of the elimination changes and identified a referral would be made if the issues continued, but no further documentation was made. There was no current documentation in the clinical record by the physician, RD or nursing staff up and to including the day of the observation. The Physician, RD and registered staff #113 were interviewed and confirmed they were unaware of the change in urine and therefore had not completed an assessment. The resident was interviewed and identified they had elimination issues for a long time. The resident was alert and independent in their wheelchair. The plan of care did not include an interdisciplinary assessment of resident #064's continence, including bladder elimination. In April 2016, the physician ordered a test to rule out an infection. The clinical team did not collaborate with each other to ensure the plan of care for resident #064 was based on an interdisciplinary assessment of the resident's continence and elimination needs. [s. 26. (3) 8.]

2. The licensee failed to ensure that the plan of care for resident #034 was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

Resident #034 had a long term medical condition requiring routine care every four hours. The plan of care was reviewed and did not have an assessment completed by the physician or a respiratory therapist, to determine the specific treatments and interventions required by the resident. The nursing staff confirmed the resident needed specific care. The registered staff #111 and #113 were interviewed and confirmed they did not implement interventions. The plan of care did not include physicians orders or direction for staff on how to care for the resident's specific medical condition. The home oxygen program or Respiratory Therapist had not completed an assessment to collaborate with the physician regarding the care. The plan of care was not completed based on an interdisciplinary assessment with respect to the care of resident #034. [s. 26. (3) 18.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Resident #015 had skin impairment. The resident was on a turning and repositioning program as an intervention to enhance healing and prevent further skin breakdown. The home's policy called "Skin and Wound Program, number LTC-E-90, and revised August 2015 directed staff to reposition residents at a minimum of every two hours or more frequently as required. The plan of care identified that the resident was to be turned and repositioned every two hours when in bed or up in the wheelchair. The clinical record was reviewed and turning and repositioning every two hours for resident #015 was not documented consistently in February and March 2016.

The Wound Care Champion was interviewed and confirmed that the PSWs were expected to document the turning and repositioning every two hours for resident #015 in Point of Care (POC). The home did not ensure that the turning and repositioning intervention under the Skin and Wound Care Program were documented. (527)

B) In April 2016, an observation was made of resident #064's urinary collection device. Staff member #113 was notified, then made an observation of the urinary collection device while interviewing the resident. The following day in April 2016, the plan of care was reviewed to follow up on the concerns, specifically the interventions and outcome. The clinical record did not include any documentation, including actions taken with respect to the observations made by staff member #113, the previous day. The registered staff #113 confirmed they did not document the observations made or the interview with the resident. The physician was interviewed the same day and verbally informed of the changes in the resident's elimination, who subsequently ordered a test to rule out an infection. [s. 30. (2)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to resident #056 in accordance with the directions for use specified by the prescriber.

In May 2016, resident #056 went to the hospital for an episode of abnormal symptoms. The resident was taking two specific medications to control their symptoms. The resident subsequently returned from the hospital. The physician completed the admission physical for the resident and changed the dosage of the two medications, to prevent another abnormal episode. On the following day the resident was administered the original dosages of both medications instead of the revised dosages. The physician's orders weren't processed and administered to the resident until the following day after returning from the hospital. The resident continued to have abnormal symptoms. This was confirmed by the Director of Care and clinical documentation. [s. 131. (2)]

Additional Required Actions:

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

WN #7: 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:
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 failed to ensure where the act or this regulation required that every resident had their personal health information within the meaning of the Personal Health Information Act, 2004, kept confidential.

The home had conducted an audit of the residents' business office records December 2015. The audit identified that seven residents' business office records for resident #031, #007, #026, #062, #020, #063, #068 were removed from the home by the Business Office Manager, which contained personal health information, including medical diagnosis, age, attending physician, Ontario Health Insurance Plan (OHIP) number and other health conditions.

The Executive Director (ED) confirmed that seven residents' business office records, containing personal health information were removed from the home by the Business Office Manager. The ED confirmed the expectation was that personal health information was not to be removed from the home; therefore the seven residents' personal health information was not kept confidential. [s. 3. (1) 11. iv.]

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 were fully respected and promoted: 11. Every resident has the right to, 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

A) The home's policy called "Nutrition and Hydration Management", number LTC-G-80, and revised August 2014, stated that the assessed hydration requirement from fluids for each resident would be documented in the resident's plan of care. A referral to the Registered Dietitian would be initiated if the resident's daily fluid intake was less than the recommended minimum intake for three consecutive days. The plan of care for resident #027 identified a minimum fluid requirement per day. The resident had a decrease in their hydration in March 2016. The resident's fluid intake decreased below their minimum

fluid requirement target for three consecutive days in March 2016. The resident was at risk for dehydration. On a specific date in March 2016, the Registered Dietitian confirmed that the home's policy required referral to the Registered Dietitian for fluid intake less than the resident's minimum requirement over three consecutive days. Registered staff #113 confirmed that a referral to the RD had not occurred for the decrease in hydration below the resident's target for three consecutive days. (107)

B) The home's policy called "Cleaning Schedules", number FSO-E-10 and revised December 2015 directed Food Service Department staff to document and initial on the schedule that the required cleaning of equipment in the food production and serving areas was completed and properly cleaned. The Dietary Aides #1 to #7 did not sign off on the cleaning schedules for their food production and serving areas consistently.

The Dietary Manager was interviewed and confirmed that the documentation by the dietary aides was an ongoing issue for the home and that staff were not adhering to the home's established standards. (527)

C) The home's policy called "Fall Interventions Risk Management (FIRM) Program, number LTC - E - 60", and revised August 2012, directed the staff to reassess a resident who was high/immediate risk for falls using the Falls Risk Assessment Tool (FRAT) upon admission and quarterly. Resident #051 was identified by the Physiotherapist (PT) on both the admission and quarterly PT assessment, as being high risk for falls. The Director of Care confirmed that the "Nursing Falls Risk Assessment Tool" was not completed at the quarterly assessment as per the home's policy. (640)

D) The licensee failed to ensure that policy named “Resident Non- Abuse – Ontario” #LP-C-20-N revised September 2014, was complied with. The policy directed staff to immediately report the suspicion of neglect to the Executive Director of the Home or, if unavailable, to the most senior Supervisor on shift at that time. In November 2015, resident #044 was observed on the floor of the resident's room by Program Aide #109. The Program Aide #109 asked for assistance from PSW #110 who refused to assist in getting the resident off the floor. During an interview of the Program Aide, it was stated they believed the resident was being neglected by the PSW. According to the policy, all staff who suspected neglect of a resident must immediately report the suspicion to the most senior Supervisor on duty. The incident occurred in the evening in November 2015, therefore the most senior Supervisor was the Charge Nurse.

The Program Aide was interviewed in March 2016, the Program Aide confirmed the

suspicion was not reported to the Charge Nurse. The Charge Nurse, RN#111 was interviewed and confirmed the suspicion of neglect was not reported by the Program Aide. (640)

E) The home's policy called "Dementia Care", number LTC-E-100, and revised August 2012 identified that responsive behaviours were an attempt to communicate an unmet need; such behaviours would be interpreted using the BC Model of Understanding Behaviour. In addition, the policy identified that all residents experiencing disruptive responsive behaviours would have a comprehensive assessment using a validated tool, such as a Physical, Intellectual, Emotional, Capabilities, Environment and Social (P.I.E.C.E.S.) assessment. Lastly the policy identified that monitoring of responsive behaviours would be completed using an objective, systematic tracking tool such as the Dementia Observation System (DOS).

Resident #036 and #057 had responsive behaviours, which resulted in resident #036 hitting resident #057 in June 2015. The clinical record was reviewed and neither resident had their behaviours interpreted using the ABC Model of Understanding Behaviour. Neither resident had a responsive behaviours assessment using a validated tool, such as a P.I.E.C.E.S., and neither resident had their behaviours monitored using the DOS tracking tool.

The Behavioural Support Officer (BSO) and registered staff #113 were interviewed and confirmed that they were expected to complete a P.I.E.C.E.S. assessment for both residents, they were expected to document the residents behaviours, and they were expected to use the ABC Model of Understanding Behaviour for resident #036 and #057. The staff did not comply with the home's responsive behaviour policy and procedures. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #016, #018 and #024 were observed during Stage 1 of the RQI to have had gaps greater than 12 centimetres (cms) between the top of the mattress and the head of the bed, which created a bed entrapment risk in zone 7. The home's policy called "Resident Bed Systems/Entrapment"; number LTC-K-25, and revised October 2014 defined "Bed Systems" as encompassing the bed frame, bed rails, head and foot boards, mattress and any ancillary accessories. The policy directed staff that when zones of entrapment were identified, these were to be corrected immediately and prior to a resident using the bed.

No bed accessories were observed to be in use to reduce zones of entrapment. There was no information added to the residents’ written plan of care about the status of their beds and what interventions were needed to be applied. The annual bed system audit for 2015 was reviewed and identified that these residents’ beds had passed all entrapment zones. The annual bed system audit 2015 further identified that “if zones 5, 6 or 7 fails then a passing grade is issued BUT these zones should be addressed to ensure resident safety.”

The registered staff #111 and #113 had no knowledge of the outcome of the annual bed systems audit and if there were any safety issues related to their residents’ beds. The registered staff indicated that the mattress, bed rails or bed frame may have been changed for resident #016, #018 or #024 in 2015, but were unable to confirm for sure. The Environmental Services Manager (ESM) identified that they had only been employed at the home for six months, and they were unsure of what corrective actions were taken, if any, as a result of the 2015 audit to address the residents’ safety.

The DOC was interviewed and was unsure if any changes were made to the beds, mattresses or bed frames for the three identified residents as a result of the 2015 annual audit. They identified that the ESM was responsible for the annual bed audit and to implement any corrective actions. The Executive Director was interviewed and was also not aware if there was any follow-up or an action plan to address the residents’ bed systems that failed zone 7 entrapment zones. The ESM and the ED were unable to provide any documentation to confirm the entrapment risks for zone 7 on the beds for resident #016, #018 and #024 were fixed. The home did not take the necessary steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails were used, (b) steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, 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. (2) Every licensee of a long-term care home shall ensure that when a resident’s pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #061's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for that purpose.

Resident #061 had a plan of care that identified chronic pain. The home's physician wrote an order for routine pain medication on a specific date in September 2015; however, the resident's Substitute Decision Maker (SDM) refused consent for the pain medication. Prior to initiating the order for pain medication an assessment of the resident's pain was not completed using a clinically appropriate assessment instrument specifically designed for that purpose. During the interview with registered staff #113, and the PSW #138 who routinely cared for the resident stated the resident routinely had pain during morning care; however, documentation did not support that the resident was assessed for pain using a clinically appropriate assessment instrument at any time after admission.

The home's policy, "Pain Assessment and Symptom Management, number LTC-E-80", and revised August 2012, directed staff to complete a pain assessment using PQRST-Quick Pain Assessment and that the resident's pain would be measured using a standardized, evidence-informed clinical tool. The nurse would choose the tool most appropriate for the resident from the following list:

Self-reporting, Visual Analogue, Faces Pain Scale, Pain Assessment in Advanced Dementia (PAINAD), Doloplus-2 Scale, Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC). The policy also directed staff to initiate a pain monitoring tool for 72 hours when new regular pain medication was ordered or discontinued, and to document in the interdisciplinary progress notes when a resident had new or changes in the level of their pain.

Registered staff #113 and #101 confirmed that the home's pain management policy was not followed, and that the resident's pain was not assessed using a clinically appropriate assessment instrument after admission and prior to pain medication being ordered. [s. 52. (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 when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, 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 failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

A) Resident #036 demonstrated responsive behaviours to staff and other residents. The resident exhibited responsive behaviours and they hit resident #057 in June 2015. The Behavioural Support Officer (BSO) and the registered staff #113 were interviewed and were not able to identify the responsive behaviour triggers, except for the other resident #057 being one of the responsive behaviour triggers for resident #036.

The plan of care was reviewed for resident #036; there were no strategies developed and implemented to respond to the resident's responsive behaviours. There were no responsive behaviour assessments in the resident's clinical record, and there was no documented monitoring when the resident was exhibiting responsive behaviours.

B) Resident #057's plan of care was reviewed and identified the resident as exhibiting responsive behaviours. The goal in the plan of care was to decrease the number of episodes of responsive behaviours; however there were no behavioural triggers identified, there were no responsive behaviour assessments, and there was no documented monitoring when the resident was exhibiting the responsive behaviours.

The BSO and staff #113 confirmed that they were expected to complete the Physical, Intellectual, Emotional, Capabilities, Environment and Social (P.I.E.C.E.S) assessment tool; identify the behavioural triggers and develop and implement strategies to address the behavioural triggers; and implement behaviour mapping for both residents' when they were exhibiting responsive behaviours. [s. 53. (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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

During the Resident Quality Inspection (RQI) a number of resident rooms had lingering offensive odours. The lingering odours were identified over a three week period in March 2016. The home's Environmental Services policies and procedures were reviewed, and the LTC Inspector was unable to locate a procedure for addressing lingering offensive odours. The housekeeping aide #172 and #176 were interviewed and they were unable to identify a procedure for addressing offensive odours. The Environmental Services Manager (ESM) and the Executive Director (ED) confirmed the home had no policy or procedures implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were developed and implemented for, (d) addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #13: 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 failed to ensure that, (a) procedures were developed and implemented to ensure that, residents' soiled clothes were collected, sorted, cleaned and delivered to the resident, and (iv) there was a process to report and locate residents' lost clothing and personal items.

A) Resident #012 identified that in October 2015 they had new clothing that were sent to the laundry and never came back to their closet. The resident identified that sometimes the staff delivered the residents' clothes and placed them in the wrong resident closets. The resident had reported their missing clothing to the unit staff and they never heard anything back. Resident #12's clothing had not been found.

B) Resident #024 identified that they had new trousers go to the laundry to be washed in the last couple of months and they have not yet been found. The resident identified that it was not unusual for laundry to go down and never come back. They still haven't found their new trousers and never had any feedback from any staff, even though they reported it to the unit staff.

C) Resident #025 identified that a very expensive pair of pants that matched their pant suit was sent to laundry approximately the first week in March 2016, and they never came back to their closet. The resident identified that they talked to the laundry person, and unit staff; however they never heard anything back from anyone and their pants were still missing.

The home's complaint logs for 2015 and 2016 were reviewed, but there were no Customer Service Reports (CSR) that identified that resident #012, #024 and #025 had made a complaint that their laundry was missing. Registered staff #111 and #113 were interviewed and confirmed that when they were notified that a resident had missing laundry, they would complete a CSR form and forward it to their supervisor. The registered staff identified that they didn't recall hearing anything that the residents had missing laundry. The ED and Manager of Laundry Services were interviewed and confirmed that they were not aware that the residents' had missing laundry and had informed the unit staff. The home did not ensure that the residents' clean laundry was delivered to them, and they did not ensure that staff were compliant with their process for residents' lost clothing. [s. 89. (1) (a) (iv)]

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 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 were developed and implemented to ensure that, residents' soiled clothes were collected, sorted, cleaned and delivered to the resident, and (iv) there was a process to report and locate residents' lost clothing and personal items, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized program of maintenance services ensured the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius.

In March 2016, the hot water temperatures were checked on all three floors at three resident hand basins and two lounge sinks and were noted to be above 49 degrees Celsius. First floor room #106 was checked mid-morning and noted to be 52.5 degrees and the lounge sink across from the nursing station was noted to be 56.5 degrees. Second floor room #211 was checked a few minutes later and noted to drop below 40 degrees, then return to between 40 and 49 degrees. It fluctuated throughout the five minute monitoring period. Third floor room #302 was then checked and it was noted to be 51 degrees and the lounge sink across from the nursing station was noted to be 51.5 degrees. The staff lounge in the basement had a water temperature of 68 degrees, however staff confirmed residents do not have access to this lounge.

Throughout the review, the water temperatures fluctuated and several residents and nursing staff identified the water was too cold for a shower or it would run hot and cold during their shower. This was confirmed by the Environmental Services Manager. [s. 90. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures were developed and implemented to ensure that, (g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and was controlled by a device, inaccessible to residents, that regulates the temperature, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged or suspected, incident of abuse of a resident that the licensee suspected may have constituted a criminal offence.

The Substitute Decision Maker (SDM) of resident #054 reported to the Executive Director that the resident alleged they were physically abused by a staff member in August 2014. The incident was reported by the resident's SDM two days later. The police were not notified of the alleged incident until the following month. The Executive Director confirmed that the police should have been notified of the incident and that there was a significant delay in contacting the police. [s. 98.]

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 appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, 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).

Findings/Faits saillants :

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

In April 2016, staff member #113 was observed wearing gloves and administering subcutaneous medication and taking a blood sample. The staff member was actively touching blood and body fluids, then returned to the medication cart, with the soiled gloves still on and touched the computer mouse on the medication cart. The staff member continued to touch items on the medication cart, with the gloves on, contaminating the items with blood and body fluids. After removal of the gloves, the staff member did not wash their hands or apply hand disinfection gel. This was confirmed by the staff member and observation by the LTC Inspector. [s. 229. (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 staff participate in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure where the act or this regulation required the licensee of a long term care home to ensure that the records of the residents of the home were kept at the home.

After an audit of the resident business records in December 2015, the home identified that seven residents' business records (resident #031, #007, #026, #062, #020,#063, and #068) and seven residents' banking information (resident #064, #065, #066, #003, #050, and #067) were missing. The Executive Director (ED) confirmed that seven residents' business office records and seven residents' banking information were missing from the home, and confirmed the expectation was that resident records and banking information were to be kept at the home. [s. 232.]

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 records of the residents of the home were kept at the home, to be implemented voluntarily.

WN #18: 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 failed to ensure that the plan of care for resident #034 set out clear directions to staff and others who provide direct care to the resident.

A) In March 2016, there was medical equipment observed sitting at the sink of a semi private room, with black mold in it. The plan of care did not include directions for the care of the equipment, nor was there a physician's order to direct the care. This was confirmed by the Director of Care (DOC). The plan of care also, did not provide clear directions to staff regarding the care of the resident's specialized device. The plan identified care was required every four hours, however it did not identify how the care was to be provided. The registered staff #113 confirmed there wasn't a plan of care that sets out clear directions regarding care of resident #034's specialized medical device and equipment. The lack of clinical documentation also confirmed the lack of clear direction in the plan of care.

B) The current plan of care for resident #064 directed staff to use a specific brief to manage the residents incontinence. Observation on a specific date in April 2016,

revealed the resident used a urinary collection device to manage their elimination needs. The resident confirmed they used a urinary collection device and not a brief. The registered staff #113 and the PSWs #119 and #138 confirmed the resident used a urinary collection device to manage their urinary elimination. The plan of care did not provide clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, (a) in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) The clinical record for resident #027 was reviewed and information in the progress notes and different sections of the plan of care referred to a type of opening the resident had and sometimes it referred to two types of openings. It was unclear from the documentation what type of opening the resident had. The Registered Dietitian (RD) confirmed the assessment terminology was not consistent in all areas and was confusing.

B) Resident #061 had a plan of care that identified chronic pain. Information on the "Pain Flow Sheet" and "Pain Assessment Inventory", both completed in August 2015, was not consistent in relation to the resident's pain. The "Pain assessment Inventory" identified the resident had moderate pain in the morning. The "Pain Flow Sheet", completed over all three shifts on the same day, identified the resident had no pain. The "Resident Admission Assessment Plan of Care" also stated the resident had both moderate pain and that the resident's family member stated the resident had no pain. During the interview with the PSW #138 who routinely cared for the resident, the PSW identified significant pain during daily morning care and during activities of daily living; however, progress notes did not routinely identify the resident had pain. Information was not consistent between the assessments of the resident's pain. [s. 6. (4) (a)]

3. The licensee failed to ensure that staff and others involved in the different aspects of care of resident #005 collaborated with each other in the development and implementation of the plan of care for the resident so that the different aspects of care were integrated, consistent with and complemented each other.

The oral hygiene plan of care for resident #005 identified the resident was both independent for oral hygiene and that the resident required one staff assistance for oral

hygiene. Documentation in the Point of Care (POC) system identified the resident was receiving oral hygiene twice daily and also indicated that the resident was consistently refusing oral hygiene on the same dates. Information was inconsistent between the different areas being documented. The resident was at risk for aspiration pneumonia and required good oral hygiene. The ADOC #102 confirmed that the documentation was not consistent and was difficult to interpret. [s. 6. (4) (b)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to resident #061 as specified in the plan.

The resident had a plan of care that instructed staff to apply heat therapy to affected areas as needed and to apply cold therapy to the affected area by the Physiotherapy department for pain management. Registered staff #113, physiotherapy aides #144 and #145, and the physiotherapist #146 confirmed the resident was not receiving the heat or cold therapy, as per the plan of care.

The resident had a plan of care that instructed staff to use a list of words with translation that was accessible in the resident's room. Registered staff #113 and the DOC confirmed that a list of words with translation was not in place to assist with communication between August and October 2015. [s. 6. (7)]

WN #19: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A) The home's policy called "Resident Non-Abuse - Ontario", number LP-C-20-ON, and

revised September 2014 stated; "Any staff member or person, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director (ED) of the Home or, if unavailable, to the most senior Supervisor on shift at that time. The person reporting the suspected abuse or neglect must follow the Home's reporting requirements to ensure that the information is provided to the ED immediately." The program aide #109 was interviewed and identified that they observed resident #044 on the floor of their room. The program aide #109 asked PSW #110 for assistance to return the resident to bed. The PSW would not assist the program aide with the resident. The program aide #109 felt this was neglect, which they stated was a form of abuse. The program aide notified their manager via email at the beginning of November 2015, the date of the incident. The program aide phoned their manager that day to tell the manager to look at their email. The Programs Manager #108 confirmed that they did receive the message via telephone and did receive the email related to the allegations on the same day of the incident, but they had not reported the abuse/neglect allegation of resident #044 until four days later. Notification to the Director was not done until five days after the allegation of abuse. The Executive Director was interviewed and confirmed the delay in reporting the allegation of abuse/neglect.The ED also confirmed that the staff did not comply with the home's "Resident Non-Abuse - Ontario" policy. (640)

B) The home's policy called "Resident Non-Abuse - Ontario", number LP-C-20-ON, and revised September 2014 directed staff members who became aware of and/or had reasonable grounds to suspect abuse of a resident must immediately report that suspicion and the information on which it was based to the Executive Director (ED) of the home, or if unavailable, then it must be reported to the most senior Supervisor on the shift at that time. The policy also identified that staff must follow the home's reporting requirements. A dietary aide #159 had reported to resident #016's mother that a staff member was verbally abusive to their daughter at the end of October 2015. The dietary aide #159 did not report the alleged verbal abuse to the ED or the most senior Supervisor in the home at the time. The resident's family member had approached the ED four days after the incident and informed them of the alleged verbal abuse by a staff member to the resident. The resident's family member was interviewed and confirmed that they had notified the home four days after the abuse of the resident and that the ED was not aware of the incident.The ED was interviewed and confirmed that the dietary aide did not follow the home's policy and procedures for immediate reporting of alleged abuse. [s. 20. (1)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an allegation of emotional and physical abuse by resident #059 was immediately investigated.

In July 2015, resident #059 reported the allegation of abuse to the charge nurse. The charge nurse did not report it to the management team, and did not initiate an immediate investigation into the allegations. The investigation was initiated the following day, and the allegations were confirmed. The PSW and the charge nurse were disciplined by the home. This was confirmed by interview with the Executive Director, Director of Care and documentation. [s. 23. (1) (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that resident #003 received individualized personal care, including hygiene care and grooming, on a daily basis.

Resident #003 was observed an appeared ungroomed over a four week period in March 2016. The written plan of care identified that the resident was shaved on shower days, which was twice weekly. The resident was interviewed and they identified their preference was to be shaved daily and they had previously communicated their preferences to the staff, but was afraid to ask again just in case the PSW #130 came back to him with negative comments. Registered staff #129 was interviewed and confirmed that the resident was showered twice weekly and was expected to be shaved on their bath days. Registered staff #129 was not aware of the resident's preferences to be shaved daily, or the resident's voiced concerns regarding PSW #130. The home did not provide individualized grooming to the resident on a daily basis. [s. 32.]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 62. Every licensee of a long-term care home shall ensure that there is a written description of the social work and social services work provided in the home and that the work meets the residents’ needs. O. Reg. 79/10, s. 62.

Findings/Faits saillants :

1. The licensee failed to ensure that the social services provided in the home met the residents’ needs.

In April 2015, resident #201 approached the LTC Inspector to inquire about moving to an apartment in the community. The resident identified they had been working with a social worker at the home until February 2016, however the social worker had left and there wasn't anyone to assist with their needs. The resident identified they had a password to access the social housing application system, however required assistance to navigate the system. The resident stated there were vacancies in the building they wished to move to, but they needed a social worker to assist them with the process of applying via the website. The resident expressed frustration about the lack of social work services at the home and identified they had many questions about the process, funding and access. The resident identified they could not get the answers without the assistance of a social worker. The Executive Director (ED) was informed by the LTC Inspector of the resident's concerns and identified a new social worker would be starting in two weeks. The resident was informed and the ED offered to assist the resident until the social worker position was filled again. [s. 62.]

WN #23: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining service that included course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

The observed lunch meal in April 2016, did not include course by course service for all residents. Desserts (ice cream for some) were placed on the tables with the entree. RPN #113 confirmed that the meal was not served course by course. The RPN stated that desserts were placed on the tables with the entrees as the food cart had to leave the dining area to serve on a different floor. The Nutrition Manager #103 stated that processes were in place to enable course by course meal service for residents (insulated carts for desserts); however, staff did not follow the identified process at the observed meal. [s. 73. (1) 8.]

2. The licensee failed to ensure that resident #063 was provided with eating aids, and assistive devices required to safely eat and drink as comfortably and independently as possible at the observed dinner meal April 5, 2016.

Resident #063 had a plan of care that required their beverages be placed in sippy cups to assist the resident with drinking independently. The resident was not provided the sippy cups at the observed meal and was provided with juice in two regular drinking glasses. The resident had a tremor in their arm and staff were observed assisting the resident with their beverages. RPN #134 stated that the assistive devices were not provided as staff were assist the resident with eating. The resident was not provided with the required assistive devices for independence with eating. [s. 73. (1) 9.]

3. The licensee failed to ensure that residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required by the resident.

At the observed dinner meal in April 2016, meals were placed on the table for residents #069 and #072. Both residents had a plan of care that directed staff to provide total assistance with eating. PSW #140 fed one resident at a time while the meals were sitting on the table. Resident #072 had their meal sitting on the table while they were waiting for assistance for 15 minutes. The menu items were to be served hot. The PSW stated both residents were difficult to feed so each resident was fed separately. [s. 73. (2) (b)]

WN #24: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 91. Resident charges

Specifically failed to comply with the following:

s. 91. (1) A licensee shall not charge a resident for anything, except in accordance with the following:
1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
2. For preferred accommodation, a resident shall not be charged more than can be charged for basic accommodation in accordance with paragraph 1 unless the preferred accommodation was provided under an agreement, in which case the resident shall not be charged more than the amount provided for in the regulations for the accommodation provided. 2007, c. 8, s. 91 (1).
3. For anything other than accommodation, a resident shall be charged only if it was provided under an agreement and shall not be charged more than the amount provided for in the regulations, or, if no amount is provided for, more than a reasonable amount. 2007, c. 8, s. 91 (1).
4. Despite paragraph 3, a resident shall not be charged for anything that the regulations provide is not to be charged for. 2007, c. 8, s. 91 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #050 was not charged for anything, except in accordance with the following: 1. For basic accommodation, a resident shall not be charged more than the amount provided for in the regulations for the accommodation provided.

In April 2016, the LTC Inspector interviewed resident #050, their friend, the Office Manager and the Executive Director regarding alleged over-payments taken from the resident's account for accommodation. During stage 1 of the Resident Quality Inspection, resident #050 identified concerns to the LTC Inspector #107 that there was more money being taken out of their account than there should be. The resident stated the payments "had been up and down like a roller coaster". At the end of March 2016, the resident's individual ledger was reviewed line by line by the home's Office Manager in the presence of the LTC Inspectors #169 and #640. Identified at that time were charges higher than the rate reduction for resident #050 for September, October and November 2015, as well as March and April 2016. The Executive Director and Office Manager confirmed the resident was over-charged for accommodation on the identified months, and the resident was charged non-sufficient fund fees at their personal bank as a result of the over-charges. The Executive Director also confirmed that the home would refund the amounts of overpayment, the NSF charges from the home and from the resident's personal bank. Resident #050 was charged more than the amount provided for in the regulations for accommodation. [s. 91. (1) 1.]

Issued on this 23rd day of June, 2016

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHLEEN MILLAR (527), HEATHER PRESTON (640), MICHELLE WARRENER (107), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2016_431527_0007
Log No. / Registre no:	004489-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 16, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	HUMBER VALLEY TERRACE 95 Humber College Blvd., Rexdale, ON, M9V-5B5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANDREW SHINDER

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. 72. (2) The food production system must, at a minimum, provide for,
(a) a 24-hour supply of perishable and a three-day supply of non-perishable foods;
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable;
(c) standardized recipes and production sheets for all menus;
(d) preparation of all menu items according to the planned menu;
(e) menu substitutions that are comparable to the planned menu;
(f) communication to residents and staff of any menu substitutions; and
(g) documentation on the production sheet of any menu substitutions. O. Reg. 79/10, s. 72 (2).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that the food production system provides for the preparation of all menu items according to the planned menu. The plan shall include, but is not limited to:

1. Review of the home's food ordering processes to ensure all menu items/ingredients are ordered and available and ordered in sufficient quantities to meet the menu requirements for all diet types and textures.

2. Review of the home's recipes to ensure they provide adequate direction for staff preparing the meals, and that recipes provide appropriate flavour, textures, consistency, etc.

3. Provide education for staff preparing meals and snacks related to preparation of the planned menu according to standardized recipes/production sheets.

4. Review of staff communication processes around product shortages and menu substitutions.

5. Develop and implement quality management processes to include audits at all meals and to monitor the provision of items according to the planned menu.

The plan shall be submitted by July 22, 2016 to Long Term Care Homes Inspector, Michelle Warrener, through e-mail to: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that the food production system provided for the preparation of all menu items according to the planned menu at the lunch meals three specific dates in March 2016, and a dinner meal in April 2016, resulting in reduced variety, quality, and nutritive value.

In March 2016, the planned menu required tuna salad on a croissant with mixed green salad or vegetable stew with cauliflower and a corn muffin. The planned menu items were not prepared and available for residents requiring texture modified menus (minced and pureed texture). Mashed turnip was prepared instead of minced cauliflower; pureed zucchini with parsley was prepared instead of pureed cauliflower; and mashed potatoes and gravy were prepared instead of a pureed corn muffin. Cook #157, who prepared the meal, confirmed that the vegetable substitutions were made due to insufficient quantities of

cauliflower; however, it was not clear why the Other substitutions were made.

2. On another day in March 2016, the planned menu required a pulled beef sandwich for residents receiving a pureed diet texture. Mashed potatoes were substituted for the pureed bread/bun at the observed meal. Dietary Aide #156 stated that the home routinely substituted mashed potatoes for bread for the pureed texture menu; however, they were unsure why the substitution was made.

3. In March 2016, the planned menu required a pureed Cobb salad (lettuce, spinach, green peppers, chicken, tomato, egg, salad dressing) with pureed bread. Substitutions were made for the pureed texture menu and staff prepared a hot pureed chicken with gravy, pureed zucchini with parsley (also substituted on another day in March 2016), and mashed potatoes with gravy. Pureed bread was not offered with the hot meal. Dietary aide #151 stated that a hot meal was prepared instead of the cold salad plate as not all residents would eat cold meals. The substitutions were not documented on the production sheets and had not been approved by the Registered Dietitian (RD).

4. The planned renal menu required a renal vegetable salad marinated (recipe contained carrots, cauliflower and Italian salad dressing); however, this was not prepared or offered for the renal menu. In March 2016, resident #048 voiced concerns to the LTC Inspector about routinely being offered foods that were not on the resident's planned renal menu. Dietary aide #151 confirmed that the renal vegetable salad was not prepared as per the planned menu.

5. In March 2016, the RD stated that staff were expected to prepare the planned menus as written and confirmed that she had not approved the menu substitutions.

6. On a specific day in April 2016, the planned menu required a creme brule tart; however, residents requiring a regular texture menu were offered white cake instead of the creme brule tart. The creme brule tarts were not available as per the planned menu.

7. Although the severity level was minimum risk, there was a pattern within the home, and despite Ministry of Health action, there continued to be non-compliance with a Voluntary Plan of Correction (VPC) previously issued in the last three years. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Order / Ordre :

The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods that prevent adulteration, contamination and food borne illness. The licensee shall:

1. Ensure that temperatures of all potentially hazardous food items are taken and recorded prior to the service of those foods to residents.

2. Provide education for staff preparing and serving foods on the importance of monitoring and recording the temperature of potentially hazardous food items prior to service to residents.

3. Develop and implement quality management processes to monitor that the required food temperatures are monitored and recorded by staff serving foods to residents.

Grounds / Motifs :

1. The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to prevent adulteration, contamination and food borne illness.

Staff were not routinely monitoring the temperature of the "Indian menu" prior to service to residents. Temperatures were not monitored for the supper meal on any date between the beginning of March to the first week in April 2016. Dietary Aide #157 confirmed that the food temperatures were to be monitored prior to service and recorded in the "Indian Food Temperature Log" book. The dietary aide confirmed that food temperature records were not available and not recorded elsewhere for those dates. During interview, both Dietary Managers confirmed that staff were required to monitor and record food temperatures prior to service of the meal.

2. Food temperature monitoring records were also not recorded for the lunch and breakfast meals on specific dates in April 2016, for the traditional menu.

3. Staff did not ensure that food temperatures were monitored to ensure the prevention of food borne illness.

4. There was potential for actual harm to residents, there was a pattern in the home of food temperatures not being monitored or recorded, and there continued to be non-compliance with a Voluntary Plan of Correction (VPC) despite Ministry of Health action. (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 29, 2016

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents, including residents #020, #053 and #059 are protected from abuse by anyone and to ensure that all residents are not neglected by the licensee or staff. The plan shall include, but not limited to the following:

1. Mandatory re-education for all staff on the home`s Abuse and Neglect policy #LP-C-20-ON, to include the Residents' Bill of Rights and Mandatory Reporting.

2. Education for all relevant staff on feeding techniques for residents at high nutritional risk and swallowing issues.

3. Education for all relevant staff on how to provide perineal care to residents.

4. Evaluate the education to ensure it is effective in providing quality and safe care to residents, and implement quality management systems for monitoring compliance with the home's Abuse and Neglect policies and procedures.

The plan is to be submitted on or before July 22, 2016 to the Long Term Care Homes Inspector, Kathy Millar by email at: kathy.millar@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone in the home.

On a specific date in March 2016, resident #020 was offered a can of gingerale by PSW #120 during the evening snack. The resident tucked the gingerale down the side of their wheelchair. PSW #142 approached the resident and forcibly

took the can of gingerale from the resident's wheelchair while the resident was holding the can. The resident was upset, tearful and their hand was hurting after the incident. The resident was cognitive, was able to communicate their needs and participated in decision making regarding their own care. Resident #073 witnessed PSW #142 yelling at resident #020 to give back the gingerale. Resident #073 also witnessed the PSW forcing the can of gingerale from resident #020's fingers and then pushed their hand away. Based on the home's investigation and a review of the home's videotape of the incident in March 2016, the employee was disciplined for abusing resident #020. The Executive Director and the DOC confirmed the incident occurred and confirmed that PSW #142 was disciplined. (527)

2. On a specific date in July 2015, resident #059 was told by a PSW that they should put themselves on the toilet. The PSW then proceeded to provide care to the resident and the resident described the care as being rough. The resident was no longer at the home for an interview, however the Executive Director and Director of Care were able to confirm the incident occurred. The plan of care directed staff to provide the assistance of one PSW at all times for care. The documentation and interview with the ED and DOC confirmed the incident occurred. (169)

3. On a specific date in July 2014, resident #053 was being fed their breakfast and the PSW that was feeding the resident, was observed forcibly pushing the resident's hand into their mouth and directing the resident to lick them. When another staff member called out to ask the PSW to stop, the PSW did not and continued to push the resident`s hand/fingers into their mouth and directing the resident to lick them. The resident was at high nutritional risk and was followed by a speech language pathologist for swallowing issues. The plan of care revealed the resident required total feeding assistance due to physical limitations and swallowing difficulties. The resident was cognitively impaired and was incapable of following verbal directions. The employee had been terminated, therefore was not interviewed, however the Executive Director (ED) and Director of Care (DOC) confirmed the incident occurred.

4. There was actual harm/risk to residents, there was a patter of staff to resident abuse in the home, and there was continued non-compliance with the Voluntary Plan of Correction (VPC) issued previously despite Ministry of Health action. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that the infection prevention and control program includes measures that prevents the transmission of infections. The plan shall include, but is not limited to:

1. Review the home's procedures to ensure that tracheostomy care equipment for resident #034 is maintained, cared for and stored in a manner that prevents the transmission of infections based on evidence based practices.

2. Develop and implement interventions based on evidence based practices for tracheostomy care and include in the plan of care for resident #034.

3. Provide education for staff on the tracheostomy care procedures developed and implemented by the home.

4. Review staff communication processes related to tracheostomy care of resident #034.

5. Develop and implement quality management processes to monitor quality and safety of care to prevent transmission of infections and to ensure compliance with the tracheostomy procedures implemented.

The plan shall be submitted by July 22, 2016 to the Long Term Care Homes Inspector, Kathy Millar by email at: kathy.millar@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that measures were in place to prevent the transmission of infections.

On two specific dates in March 2016, resident #034's medical equipment was observed sitting on the sink counter of a shared resident room with black mold in it. Resident #034 had a medical condition which required a specialized device and equipment. Both residents in the room use the sink and the equipment was not stored in a way to prevent the transmission of infection. The staff confirmed the medical equipment was not stored in a manner to prevent the transmission of infection, nor was the equipment clean and sanitary. The registered staff identified that the medical equipment with black mold in it was applied to the resident's specialized device, it would generate airborne mold spores throughout the shared room allowing for the transmission of infection toward the room mate and staff. This was confirmed by the registered nursing staff.

2. There was potential for harm to the resident, and although this was isolated, there was a history of non-compliances related to Infection Prevention and Control in the home. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that an interdisciplinary assessment of resident #034's tracheostomy care, and #064's continence, including bowel and bladder elimination. The plan shall include, but is not limited to:

1. The physician and any necessary interdisciplinary team members are included in the assessments.

2. Referrals to specialists shall be included in the plan, if deemed necessary by the interdisciplinary team.

3. The plan of care for resident #064 shall be updated to include a system of monitoring the characteristics of the urinary output of the resident and steps taken when there is evidence of any changes to the urinary system.

4. Review of the communication processes among the interdisciplinary team to ensure reporting of significant changes in resident condition.

5. Develop and implement quality management processes to monitor the provision of care for residents with significant changes in condition and interdisciplinary assessments.

The plan shall be submitted by July 22, 2016 to Long Term Care Homes Inspector, Kathy Millar by email at: kathy.millar@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of resident #064's continence, including bladder and bowel elimination.

In April 2016, an observation was made of resident #064`s urinary collection device. The clinical record was reviewed and indicated the Registered Dietician (RD) was monitoring the resident`s laboratory values and was unaware of any issues. The physician made a clinical notation in September 2015 of the elimination changes and identified a referral would be made if the issues continued, but no further documentation was made. There was no current documentation in the clinical record by the physician, RD or nursing staff up and

to including the day of the observation. The Physician, RD and registered staff #113 were interviewed and confirmed they were unaware of the change in urine and therefore had not completed an assessment. The resident was interviewed and identified they had elimination issues for a long time. The resident was alert and independent in their wheelchair. The plan of care did not include an interdisciplinary assessment of resident #064's continence, including bladder elimination. In April 2016, the physician ordered a test to rule out an infection. The clinical team did not collaborate with each other to ensure the plan of care for resident #064 was based on an interdisciplinary assessment of the resident's continence and elimination needs.
(169)

2. The licensee failed to ensure that the plan of care for resident #034 was based on an interdisciplinary assessment with respect to the resident's special treatments and interventions.

The plan of care was reviewed and did not have an assessment completed by the physician or a respiratory Therapist, to determine the specific treatments and interventions required by the resident. The nursing staff Confirmed the resident needed specific care. The registered staff #111 and #113 were interviewed and confirmed they did not implement interventions. The plan of care did not include physicians orders or direction for staff on how to care for the resident's specific medical condition. The home oxygen program or Respiratory Therapist had not completed an assessment to collaborate with the physician regarding the care. The plan of care was not completed based on an interdisciplinary assessment with respect to the care of resident #034.

3. There was actual harm/risk to the resident(s), and although these were isolated, there were one or more related non-compliances in the last year. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that all resident sunder a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. The plan shall include, but is not limited to:

1. Review and update the plan of care for resident #064 to include a process for regular documentation of pertinent clinical information is completed, including urinary systems.

2. Provide education for registered staff on the requirements from the College of Nurses related to documentation.

3. Develop and implement quality management processes to ensure monitoring of all pertinent clinical information is documented in the clinical health records for all residents, including resident #015 and #064.

The plan shall be submitted by July 22, 2016 to Long Term Care Homes Inspector, Kathy Millar by email at: kathy.millar@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

In April 2016, an observation was made of resident #064's urinary collection device. Staff member #113 was notified, then made an observation of the urinary collection device while interviewing the resident. The following day in April 2016, the plan of care was reviewed to follow up on the concerns, specifically the interventions and outcome. The clinical record did not include any documentation, including actions taken with respect to the observations made by staff member #113, the previous day. The registered staff #113 confirmed they did not document the observations made or the interview with the resident. The physician was interviewed the same day and verbally informed of the changes in the resident's elimination, who subsequently ordered a test to rule out an infection. (169)

2. Resident #015 had skin impairment. The resident was on a turning and repositioning program as an intervention to enhance healing and prevent further skin breakdown. The home's policy called "Skin and Wound Program, number LTC-E-90, and revised August 2015 directed staff to reposition residents at a minimum of every two hours or more frequently as required. The plan of care identified that the resident was to be turned and repositioned every two hours when in bed or up in the wheelchair. The clinical record was reviewed and turning and repositioning every two hours for resident #015 was not documented consistently in February and March 2016.

The Wound Care Champion was interviewed and confirmed that the PSWs were expected to document the turning and repositioning every two hours for resident #015 in Point of Care (POC). The home did not ensure that the turning and repositioning intervention under the Skin and Wound Care Program were documented.

3. There was actual harm/risk to residents, and although isolated, there was one or more unrelated non-compliances in the last three years. (527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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

Order / Ordre :

The licensee shall prepare, submit, and implement a plan that outlines how the home will ensure that all drugs are administered to all residents according to the directions of the prescriber. The plan shall include, but is not limited to:

1. Develop and implement a system to ensure medications are provided to residents in a timely way and according to the directions of the prescriber.

2. The pharmacy shall be included in the plan to ensure timely delivery of new medications or changes in dosages, that ensures the medications are available for administration according to the requirements of the College of Nurses.

3. Provide education to registered staff on these requirements.

4. Develop and implement quality management processes to monitor compliance of medications according to the College of Nurses.

The plan shall be submitted by July 22, 2016 to Long Term Care Homes Inspector, Kathy Millar by email at: kathy.millar@ontario.ca

Grounds / Motifs :

1. The licensee failed to ensure that drugs were administered to resident #056 in accordance with the directions for use specified by the prescriber.

In May 2016, resident #056 went to the hospital for an episode of abnormal symptoms. The resident was taking two specific medications to control their symptoms. The resident subsequently returned from the hospital. The physician completed the admission physical for the resident and changed the dosage of the two medications, to prevent another abnormal episode. On the following day the resident was administered the original dosages of both medications instead of the revised dosages. The physician's orders weren't processed and administered to the resident until the following day after returning from the hospital. The resident continued to have abnormal symptoms. This was confirmed by the Director of Care and clinical documentation.

2. This was an isolated case; however there was one or more related non-compliances in the last three years, and there was actual harm/risk to the resident. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 16th day of June, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Kathleen Millar

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