Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 09, 2017;	2017_631210_0004 (A1)	003227-17	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

SLAVICA VUCKO (210) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date was changed from July 27, 2017 into August 27, 2017, to reflect 120 days for DR compliance

Issued on this 9 day of May 2017 (A1)

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

Original report signed by the inspector.

Ontario

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

SLAVICA VUCKO (210) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 7, 8, 9, 10, 13, 14, 15, 16, 17, 21, 22, 23, 24, 27, 28, March 1, 2, 3, 6, 7, 8, 9, and 14, 2017.

The following Critical Incidents were inspected:

Related to Prevention of Abuse: Log # 012107-16, 028457-16, 026681-15, 035109-16, 000640-17, 003402-17

Related to Prevention of Falls: Log # 028522-16, 002180-17

Related to Prevention of Restraints; Log # 000699-17

Related to Safe and Secure Home: Log # 029918-16

Related to Hospitalization: Log #005033-17

The following complaint intakes were inspected:

Related to Plan of Care: Log # 008823-16, 260280-16

Related to Reporting and Complaints: Log # 025558-16

Related to Continence Care and Bowel Management: Log # 024532-16

Related to Prevention of Abuse and Neglect: Log # 028940-16, # 028935-16

The following follow up intakes were inspected: Log #002824-17, (Inspection #: 2016_431527_0007, Order # 001, 002, 003, 004, 005, 006, 007), Log # 003924-17 (Inspection # 2017_405189_0003)

During the course of the inspection, the inspector(s) spoke with the acting Executive Director (ED), Director of Nursing Care (DONC), Assistant Director of Nursing Care (ADONC), Staff Educator, Social Worker (SW), Registered staff, Personal Support Workers (PSWs), Registered Dietitian (RD), Food Service Manager (FSM), Dietary Aids (DA), Environmental Services Manager (ESM), Housekeeping Staff, Physiotherapist (PT), Laundry personnel, Receptionist, Recreation and Activation, Program Manager, Recreation Program Assistants, Cooks, Family Council president, Residents' Council President, Resident(s) and Substitute Decision Maker(s) (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control practices, dining and snack delivery service, reviewed clinical health records, minutes of Residents' Council and Family Council meetings, minutes of relevant committee meetings, and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

- **8 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (2)	CO #007	2016_431527_0007	653
LTCHA, 2007 s. 19. (1)	CO #001	2016_405189_0014	210
O.Reg 79/10 s. 26. (3)	CO #005	2016_431527_0007	210
O.Reg 79/10 s. 30. (2)	CO #006	2016_431527_0007	596
O.Reg 79/10 s. 72. (2)	CO #001	2016_431527_0007	500
LTCHA, 2007 s. 86. (2)	CO #004	2016_431527_0007	210

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. (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 has failed to 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.

On June 16, 2016, a Compliance Order (CO) #002 was issued as follows:
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:
- Ensure that temperatures of all potentially hazardous food items are taken and recorded prior to the service of those foods to residents.
- Develop and implement quality management processes to monitor that the required food temperatures are monitored and recorded by staff serving foods to residents.
The order compliance date was July 29, 2016.

A review of the Cook's Production Daily Temperature Record- Main Kitchen revealed that during the period of the inspection, there were no temperatures measured and recorded for all potentially hazardous food items.

- A review of Cook's Production Daily Temperature Record- Main Kitchen for a specific menu during two months revealed there were no temperatures measured and recorded for all potentially hazardous food items during three occasions for lunch and dinner and eleven occasions for dinner.

Interview with Cook #152 and Cook #151 revealed that the food production temperature should be measured and recorded at all three meals breakfast, lunch and dinner on the above mentioned dates and meals.

- A review of Meal Service Daily Temperature Record for the Specific Menu for the specific floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on seven occasions at lunch, three occasions at dinner and two occasions no temperature recorded for all meals.

- A review of Meal Service Daily Temperature Record for the Traditional Menu for the second floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on two occasions for dinner and one occasion no temperature recorded for all three meals, record missing.

- A review of Meal Service Daily Temperature Record for the Specific Menu for the second floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on three occasions no temperature recorded for

lunch, three occasions no temperature recorded for dinner, three occasions no temperature recorded for all meals.

- A review of Meal Service Daily Temperature Record for the Specific Menu for the third floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on the five occasions no temperature recorded for lunch.

A review of the home's policy #CARE17-O20.02, entitled "LTC- Food Temperature Checklist", reviewed July 31, 2016, indicated temperatures are to be taken at the end of the cooking process and recorded under cooking temperature on the Cook's Meal Production Daily Temperature Record. Cook/Food Service Workers record the temperatures of the menu items for all diet types and textures immediately after taking temperatures and records on the Meal Service daily Temperature Record.

Interview with Dietary Aide #145, #146, #148, and Late Cook #147 confirmed that staff are expected to measure and record food temperatures for all food items for all meals during production and prior to serve meals to residents for both Traditional and Indian menus.

Interview with FSM confirmed that staff are expected to measure and record food temperatures for all food items and for all meals during production and prior to serving meals to residents for both Traditional and Indian Menus. FSM also confirmed that he/she does monitor staff measuring and recording food temperatures on a daily basis and if he/she finds any discrepancy he/she will communicate immediately with staff. The FSM was unable to explain the above mentioned missing entries for food temperatures in the specified period.

An interview with FSM, revealed that FSM monitors staff to ensure that they monitor and record temperatures on a daily basis however FSM was unable to present any tools used for monitoring and was unable to explain the missing entries of temperatures in food production and food service temperature log in the specified period.

A review of the home's quality management dietary related audits failed to reveal audits conducted to monitor that the required food temperatures are monitored and recorded by staff serving foods to residents. A review of the various kinds of dietary audits presented by the home did not include a criteria for observing staff or for monitoring and recording temperature.

The severity 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 a non-compliance with the Compliance Order (CO) despite Ministry of Health action.

The licensee is currently in non-compliance with s.72. (3), as a result of a failure to comply with the requirements listed in CO #002 in previous order which corresponds with inspection #2016_431527_007, compliance date July 29, 2016. As a result of the home not complying with requirements of the order that was due on July 29, 2016, the order is being reissued. [s. 72. (3) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 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 :

The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On June 16, 2016, a Compliance Order (CO) #003 was issued as follows:
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 inspector.
The home was in compliance with requirements #1, 2, 3, 4.

The following non-compliance is related to two critical incident reports, one in 2016, and another one in 2017, alleging resident to resident abuse involving resident #012 and #010.

Resident #010 was admitted to the home on a specified date. Review of resident #010's CCAC application noted resident's cognitive status was mildly impaired, with no behavioural issues identified.

According to the progress notes on a specified date one month after the admission, in evening time resident #010 was noted to exhibit socially inappropriate behaviour towards resident #013. According to the BSO PSW resident #010 touched resident #013 trying to comfort him/her, because he/she seemed sad. The same day another resident reported to the nurse that resident #010 was previously seen touching resident #013 (with severe cognitive impairment). An interview with ADOC revealed the resident who reported the touching was not able to give clear description of the nature of the touching. The reporting resident was discharged from the home and not interviewed by the inspector.

A review of the written plan of care revealed the section for responsive behaviour was revised to include that resident #010 is to be monitored to prevent him/her from touching other residents, staff to check the resident for safety every one hour. According to progress notes, after the incident, the resident was prescribed a specified medication, for treatment of inappropriate behaviour.

A review of the responsive behavior written plan of care after the incident, revealed the resident would do better on a 1:1 basis with activation and no group programs for the resident. The written plan of care did not include a section for recreation and leisure activities. A review of resident #010's recreation participation report for three months, revealed the resident participated in 13 group programs on multiple occasions. An interview with the Program Manager, revealed unawareness that resident #010 would do better with activities on a 1:1 basis as part of managing the responsive behaviour and he/she confirmed that the section for activities was missing in the written plan of care. The Program Manager updated the written plan of care with 1:1 activities during the inspection process, and included the department that was responsible for implementing.

On a later specified date, resident #010 was moved to another floor unit. A review of the written plan of care and progress notes revealed he/she was noticed taking another resident from his/her initial floor to his/her room on the new floor but they were separated in a timely manner by staff. The same period, the care plan was revised and 30 minute monitoring of resident #010 was initiated. Review of progress notes revealed the resident was on behaviour mapping, Dementia Observation System (DOS) and Antecedents-Behaviour-Consequences (ABC) model.

According to Physician's order, one month after the resident was moved to another floor, the medication for treating his/her innapropriate behaviour was decreased because the resident did not present with inappropriate behaviours. According to the care plan the 30 minutes monitoring remained in effect.

On a specified date resident #010 was observed by recreation staff in the unit TV area, beside the post, across the nursing station, to be standing in front of resident #012 and inappropriately touching the resident. According to the CI and progress notes the police, Substitute Decision Maker (SDM) and the Physician were notified and one to one monitoring was ordered. DOS observation was initiated for four days.

On a later specified date, an external consultant discontinued the one to one observation because the resident did not present with a similar behaviour but according to the written plan of care the 30 minute observation was still active.

On a specified date, the home's behavioural support Ontario (BSO) committee created an action plan for resident #010 to be involved in activity programs.

Interview with BSO lead PSW revealed it was either her responsibility or the one to one staff to make sure the resident is involved in the activities, there was no documentation to support the evaluation of these activity programs as part of the behavioural support action plan.

On another specified date resident #010 was noted by a PSW in the sunroom to be standing in front of resident #012 exhibiting socially inappropriate behaviour. The residents were separated, police and SDMs were notified. The written plan of care was updated stating the resident was not supposed to go into the sun-room unsupervised.

On a later specified date, the Physician increased resident #010's medication for the inappropriate behaviour and ordered one to one monitoring. During the inspection resident #010 was still on one to one monitoring.

According to interview with Social Worker (SW), on a specified date, resident #012 was moved to another floor for his/her safety after the two incidents.

A review of resident #010's documentation 30 minute safety monitoring flow sheets for the period of three months, revealed missing documentation on twelve occasions during different shifts. There was no set up for staff to document in the time period between 0330 hours (hrs) and 0730 hrs, and 90% of the documentation between 1430 hrs and 2230 hrs was missing. Interview with RAI Coordinator and DOC revealed there was a glitch in the Point of care (POC) documentation system and the set up for documentation is for staff who works from 0700 to 1500 hrs but the PSWs on 3rd floor work from 0600 hrs to 1400 hrs, and confirmed that for the period between 0330 hrs and 0730 hrs there was no set up for staff to document and for the second period between 1430 hrs and 2230 hrs most of the documentation was incomplete because the staff was leaving at 1400 hrs and 2200 hrs and in order to document for the time period after they leave or before they come they have to switch the assignment in the computer and confirmed they were not doing that.

According to the Care Pathway for Responsive Behaviour, part of the policy section for Dementia Care Care3-P10, dated July 31, 2016, stated if the behaviour is high risk and threatening to residents and/or staff and maybe unpredictable in nature, the staff has to ensure resident and staff safety, notify the physician, request 1:1, identify and document behaviour including specific description of behaviour (verbal, physical, aggressive, non-aggressive), start behaviour monitoring and continue a

minimum of four days (all shifts). If the behaviour is not reduced or solved staff to consult appropriate resources: Psychiatrist, Psychologist, Geriatric Mental Health, Regional Manager Clinical Services (CNS), and implement recommendations. Further, under the tools for monitoring responsive behaviours there is an identified tool with 10 codes that describe the responsive behaviour to be monitored. Interview with DOC revealed the home did not use this tool for tracking resident #010's responsive behaviour but used the DOS tool because they considered it to be a type of responsive behaviour causing risk to other residents and they can use either tool.

Interviews with registered staff revealed that the process for assessing and referring a resident with responsive behaviour is as follows: when a resident presents with a responsive behaviour they document the behaviour and send a referral in the responsive behaviour binder to the BSO lead PSW who will further communicate with the Psychogeriatrician or the Psychogeriatric Resource Consultation Program (PRCP) consultant from the Toronto Outreach team. If it is urgent high risk behaviour the nurses will contact the home's physician. Interview with the BSO lead PSW revealed she is responsible for making sure the DOS and ABC model forms are initiated and filled out properly by staff and to communicate with the Psychogeriatrician. Interview with the home's educator revealed that the Psychogeriatrician and the PRCP consultant perform regular monthly visits to the home; the Psychogeriatrician to perform assessments and the PRCP consultant to provide support with responsive behaviours and education to staff if needed. There is a paper form referral for the Psychogeriatrician from CAMH and the PRCP consultant is available by phone and email for urgent responsive behaviour support. The paper referral form for the Psychogeriatrician is available on the units and contact from the PRCP consultant is available only with the Educator and BSO Lead PSW.

According to interview with the home's educator the PRCP consultant did not come to the home on specified dates during two months, and according to the Social Worker interview he/she did not come because there was an outbreak in the home. The home was not able to provide evidence that the PRCP consultant was contacted after the incidents, for the incident between resident #010 towards resident #012 according to the home's policy for Responsive behaviour referrals to specialized resources.

Interview with the PRCP consultant revealed he/she does perform regular monthly visits to the home to provide education and support to staff for residents with

responsive behaviour, and during the meetings the home has to present the case from the collected information, observation sheets, and progress notes. The home has to take notes from the consultation meeting and update the resident care plan accordingly with the interventions applied. He/she indicated he/she visited the home sometimes after the incidents but he was not presented with the incidents of resident #010, nor did the home's staff take notes from the consultation meeting. Further, he/she indicated he/she is accessible by phone and email for urgent consultations. He/she visited the home on a specified date two months after the incidents, and advised the home to involve the family in the resident responsive behaviour assessment and determining triggers. Certain facts about the resident the inspector was not able to locate in any clinical records or assessments of resident #010's responsive behaviour. He/she stated the resident would benefit from activities involving working with hands such as holding or folding towels.

The severity level was actual risk of harm, the scope of this non-compliance is a pattern as resident #010 poses a risk because he/she continued to exhibit inappropriate touching of residents and exposing him/herself in an inappropriate manner, there continued to be noncompliance with a Compliance Order (2017_405189_0003) and Compliance previously issued (2015_405189_0006, 2016_431527_0007, 2016_405189_0014 (A3)) in the last three years. [s. 19. (1)]

Additional Required Actions:

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

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 101. Conditions of licence

Specifically failed to comply with the following:

s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the Act: it is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts.

On June 16, 2016, a Compliance Order (CO) #001 was issued under s. 72. (2) as follows:
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 order compliance date was September 30, 2016.
The home was in compliance with requirements #1, 2, 4, 5, listed in the CO #001.

A review of the home's education record revealed the home failed to comply with requirement #3 listed in the CO #001. The home failed to provide education for staff preparing meals and snacks related to preparation of the planned menu according to standardized recipes/production sheets. The home presented a list of eight dietary staff signatures indicating education attendance, however, the list did not identify the education topic. The eight staff members were all involved in meal and snack preparation. Interview with staff did not reveal specific information about the topics of education.

Interview with FSM, DOC and ED were unable to provide a reason for not complying with the education requirement as indicated in the order. FSM and Staff Educator commenced this education after it was notified by the inspector, however it was conducted five month after the compliance date.

Although the severity level was minimum risk, scope is isolated within the home, and despite Ministry of Health action, there continued to be noncompliance with a Compliance order (CO) previously issued in the last three years. Currently the home is compliant with s. 72(2).

As a result of the home not complying with requirement #3 of the order due September 30, 2016, the order is being issued under s. 101. (3). [s. 101. (3)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 30. Protection from certain restraining

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).
2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was not restrained, in any way, for the convenience of the licensee or staff.

Record review of Critical Incident (CI) report revealed that a CI was submitted to the MOHLTC on a specified date, reporting that resident #043's spouse informed the home that on two occasions, a PSW restrained the resident by placing him/her in a wheelchair and tilted it until the next shift started.

Record review of resident #043's clinical record did not include a physician's order for use of a tilt wheelchair, nor consent from resident or SDM for the same. Record review of the resident's most recent plan of care did not include the use of a tilt wheelchair.

Interviews with resident #043's spouse revealed that resident #043 ambulated independently and did not use a wheelchair as a mode of transportation, nor owned one. He/she stated that he/she requested to see the video surveillance of the hallway and he/she and the DOC watched the video together; on the video, they saw an identified PSW putting the resident in another resident's wheelchair

and tilted the wheelchair backwards on a specified date during evening shift. The resident was left in the TV area of the specified unit in front of the nursing station when the evening shift ended. Resident #043's spouse stated that resident #043 should not have been restrained in another resident's wheelchair for an extended period of time, without his/her consent and a physician's order.

Interview with PSW #166 reported that he/she worked during two specified evening shifts and resident #043 was ambulatory and prone to falling. The resident would wander and required constant monitoring. When tired the resident would kneel down on the floor, fall and/or bump into objects hurting herself. PSW #166 reported that on two specified dates, after asking permission from registered staff #130, he/she assisted the resident into another resident's wheelchair, tilted it and left him/her sitting in the TV area in front of the nursing station. On both evenings it occurred shortly after the resident's one to one caregiver went home for the evening. PSW #166 stated that the resident had one to one monitoring everyday during the day shift and up until specified time in evening and leaving the resident in the titled wheelchair was for his/her own safety. The PSW stated that he/she was not aware of what was in the resident's plan of care and did not check it after starting to work with the resident on the floor a few weeks prior.

Interview with RN #130 revealed that he/she worked evening shift on two specified dates, when resident #043 was wandering up and down the corridors. Resident #043 was at high risk for falls and would often kneel down on the floor and sometimes fall when wandering; the resident did not use or own a wheelchair, but had a staff providing one to one monitoring daily. On two specified dates RN #130 gave PSW #166 permission to assist resident #043 into another resident's wheelchair, tilt it then left the resident in front of the nursing station where he/she would be stationed. No seat-belt was used while the resident was in the wheelchair, and he/she was left sleeping in the tilt wheelchair during the night when PSW #166 and RN #130 went home. RN #130 stated that he/she was aware of the home's restraint policy, that the resident did not have a physician's order for use of the tilt wheelchair, nor consent from resident or SDM, however felt that since the home did not fulfill their obligations to provide one to one monitoring for the resident during the nights, he/she had to keep resident #043 safe from falling and injuries.

Interview with PSW #162 revealed that he /she was assigned to resident #043 during the night shifts on two specified dates, and when he/she started the night shift noticed the resident was sitting in another resident's wheelchair, sleeping in

front of the nursing station, for the first time. He/she was aware that the use of the tilt wheelchair was not included in the resident's plan of care, but thought it would protect the resident from falling. Resident #043 was unsteady on his/her feet, wandered the corridors and staff would have to hold him/her up to prevent the resident from going down on his/her knees onto the floor. PSW #162 reported that he/she assisted resident #043 out of the tilt wheelchair into the bed at night during two specified dates. There was no one to one monitoring for the resident on the night shift and it was difficult for two PSWs to provide care for 40 residents on theunit while monitoring resident #043 constantly.

Interview with RN #165 revealed that he/she worked the night shift on a specified date, and didn't remember seeing resident #043 tilted in another resident's wheelchair in front of the nursing station. Resident #043 did not own or use a wheelchair, was unsteady on his/her feet, was at high risk for falls and wandered the corridors and into other residents rooms. On the night shift, the PSW staff would sometimes remove the resident from the tilt wheelchair around midnight after completing rounds, and assisted him/her to bed. The resident would get out of bed, continue to wander around and sometimes fall. There was no one to one staff for monitoring resident #043 on the night shift, only on the day shift and up until late evening hours, and not enough staff on the night shift to properly monitor resident #043 and care for all other residents. RN #165 stated that he/she was familiar with the home's restraint policy and aware that there was no physician's order for use of the tilt wheelchair, and no consent from resident or SDM, but leaving the resident in the tilt wheelchair kept him/her safe.

Inspector's review of the home's video surveillance revealed that resident #043 was assisted into a wheelchair, tilted and placed in front of the nursing station by PSW #166 at evening time on two specified dates. RN was seen nearby at the nursing station. PSW #162 on the night shift was seen pushing the resident away from the nursing station at two specified dates and the resident remained in the same spot, in front of the nursing station.

Interview with the DOC revealed that he/she reviewed the home's video surveillance for the two specified dates, for evening and night shifts. Resident #043 was ambulatory and the use of a tilt wheelchair was not included in the resident's plan of care, with no physician's order or consent from SDM. RNs #130, #165, and PSWs #162 and #166 did not follow the home's restraint policy and should not have restrained the resident using another resident's tilt wheelchair on two specified dates, due to the resident's risk for fall and wandering throughout the

shifts. Restraining the resident was not necessary to prevent serious bodily harm to the resident or others. The above mentioned staff were disciplined. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are not restrained, in any way, for the convenience of the licensee or staff, and are not restrained other than in accordance with section 31 or under the common law duty described in section 36, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

Dining room observation on the main floor on a specified date during lunch meal revealed that PSW #155 was assisting resident #026 by using a tablespoon. PSW

#155 was observed sitting parallel on the one side of the resident and feeding turning his/her hand towards the resident and feeding the resident from the resident's side.

A review of the resident's written plan of care revealed that the resident is at moderate nutritional risk, required support for eating and swallowing due to decline in health and the goal was to maintain the resident's safe chewing and swallowing experience.

Interview with PSW #155 confirmed that he/she should have used a teaspoon to provide feeding assistance to the resident.

Interview with PSW #100 who witnessed the above mentioned occurrence confirmed that PSW #155 should have used a teaspoon to provide feeding assistance to the resident to maintain the resident's safety.

Interview with RPN #135 revealed that PSW #155 should have used a teaspoon to provide feeding assistance to the resident, using a tablespoon is not a safe feeding technique. RPN #135 also confirmed that the resident is having spitting behavior and therefore PSW #155 had to assist the resident sitting from the side. RPN #135 confirmed that it is indicated in the resident's written plan of care, however when the inspector reviewed the resident's written plan of care revealed that the intervention from sitting from the side to provide feeding assistance was initiated on the same day, once the inspector notified it to the RPN #135.

A review of the home's policy #CARE17-040.01, entitled "LTC-Pleasurable Meal Service Strategies", reviewed July 31, 2016, indicated cutlery is available for residents who require assistance with eating includes two teaspoons.

Interview with PSW #100, FSM and Staff Educator confirmed that staff are required to use a teaspoon to provide feeding assistance to residents to maintain their safety. [s. 73. (1) 10.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Dining room observation conducted by the inspector on a specified date during lunch meal revealed that resident #021 received a specific food item contrary to the resident's diet order.

A review of a diet sheet on a specified date, revealed that the resident is on a specified diet.

A review of the resident's written care plan revealed that the resident was on the specified diet since a specified date. A review of the progress note made by Registered Dietitian (RD) entitled "Nutrition Assessment", on a specified date, revealed that the resident had food intolerance to a specific food.

Interview with the resident's Substitute Decision Maker (SDM) revealed that absolutely the resident is not allowed to have the specific food and it is indicated in his/her plan of care. Interview with PSW #100, and RPN #135 revealed that the resident is on a specific diet and cannot consume specific food and he/ she replaced the resident's meal after the inspector notified him/her.

Interview with Dietary Aide #101 revealed that the resident cannot consume the specific food and it should not have been served to the resident.

A review of the home's policy #CARE7-010.06, entitled "Therapeutic Diets and Fluid/ Texture Modification", revised January 1, 2017, indicated the specified diet excludes the specific food item the resident was served. A review of the home's policy #CARE17-P40, entitled "LTC-Meal Service", reviewed July 31, 2016, indicated staff are attentive to resident's diets, special needs, and preferences.

Interview with FSM and RD confirmed that the resident's diet was specific, and the resident can have specific type of food but not the kind of food he/she was served.

Interview with the ADOC revealed that the resident should have received the diet as per the plan of care. [s. 6. (7)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

According to O.Reg 79/0 s. 136(4) The licensee is required to where a drug that is to be destroyed is a controlled substance, the drug destruction and disposal policy must provide that the team composed of the persons referred to in clause (3) (a) shall document the following in the drug record:

1. The date of removal of the drug from the drug storage area.
2. The name of the resident for whom the drug was prescribed, where applicable.
3. The prescription number of the drug, where applicable.
4. The drug's name, strength and quantity.
5. The reason for destruction.
6. The date when the drug was destroyed.
7. The names of the members of the team who destroyed the drug.
8. The manner of destruction of the drug. O. Reg. 79/10, s. 136 (4).

Record review of the home's policy titled "Medication Disposal - Controlled Substances/ LTCH's" policy number 5.8.1 revised July 2014, indicated the

following under procedure:
-In the presence of two registered personnel, the remaining quantity of the drug is "circled" on the individual count sheet and subsequently documented in the space provided. A diagonal line is drawn through any remaining spaces on the individual count sheet.
-The reason for destruction is documented on the individual count sheet either manually or by circling one of the reasons provided.
-Each of the two registered personnel sign and date the form in the spaces provided.
-At the direction of the Home and/organization, and recommended by Classic Care Pharmacy for risk management reasons, each of the two registered personnel complete an entry on the Controlled Substance Destruction Log.
-The resident's individual count sheet is wrapped and/or affixed to the controlled substance for destruction which in the presence of both registered personnel is witnessed being placed in the double-locked location designated for controlled substances awaiting disposal.

On a specified date and time, on a specified unit, inspector #653 and Registered Practical Nurse (RPN) #112 reviewed the narcotic count documentation in conjunction with the current narcotic supply of medication.

Inspector #653 and RPN #112 observed resident #031’s individual narcotic and controlled drug count sheet for a specified medication and the blister pack was missing from the narcotic binder. Resident #031's specified medication blister pack indicated specific administration. The narcotic blister pack had three tablets remaining, and was included in the daily shift count.

Review of resident #031’s three month medication review signed by the physician on a specified date, indicated that the order for his/her specified medication was changed to "as needed" administration.

RPN #112 notified the ADOC of the above mentioned discrepancy. The ADOC found resident #031’s individual narcotic and controlled drug count sheet for the specified medication in the filed documents.

Record review of resident #031's individual narcotic and controlled drug count sheet revealed a diagonal line drawn through the remaining spaces and “D/C”(discontinued) written in the middle of the sheet. There were no signatures by registered staff at the bottom of the sheet. The reason for destruction and the

remaining quantity were not documented.

During an interview, the ADOC stated that the home's expectation was for registered staff to discard resident #031's discontinued narcotic as per the home's policy. The ADOC acknowledged that the home's policy on medication disposal was not complied with. [s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, 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 has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported was immediately investigated: Abuse of a resident by anyone.

Record review of a Critical Incident System (CIS) submitted by the home on a specified date in 2015, to the Director, indicated an incident of resident to resident abuse.

During a telephone interview, the previous Director of Care (DOC) stated that an investigation was done by the home regarding the incident, and that the investigation notes related to the above mentioned incident would have been compiled with the associated CIS.

During an interview, the ADOC stated that he/she could not find the home's investigation notes related to the above mentioned CIS. The ADOC further indicated that he/she could not confirm that an investigation had been conducted by the home related to the incident, as he/she could not find any investigation notes. [s. 23. (1) (a)]

Issued on this 9 day of May 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SLAVICA VUCKO (210) - (A1)

Inspection No. / No de l'inspection : 2017_631210_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 003227-17 (A1)

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

Report Date(s) / Date(s) du Rapport : May 09, 2017;(A1)

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 : Heather Reuber

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2016_431527_0007, CO #002;

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 (included in the regular traditional menu as well as Indian menu) are taken and recorded at the end of the cooking process during production.

2. Ensure that temperatures of all potentially hazardous food items (included in the regular traditional menu as well as Indian menu) are taken and recorded prior to the serving of those foods to residents.

3. Provide education for all dietary staff who are involved in preparing and serving foods on the home's policy on food temperature, importance of monitoring and recording the temperature of potentially hazardous food items (for regular traditional menu and Indian menu) prior to serving to residents. Ensure a documented record is kept identifying the topic of the education, the material used during the education, the dates education is provided to the staff and the signature of staff who receive the education.

4. Develop and implement quality management processes to ensure that staff are measuring and recording food temperatures at the end of cooking process during food production as well as prior to the serving of those foods to residents for all potentially hazardous food items included in the regular traditional menu as well as Indian menu. With the identification of any discrepancy, the home shall evaluate the effectiveness of the above mentioned education and re-educate the staff involved regarding the home's policy on food temperature.

Grounds / Motifs :

1. The licensee has failed to 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.

On June 16, 2016, a Compliance Order (CO) #002 was issued as follows:

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:
- Ensure that temperatures of all potentially hazardous food items are taken and recorded prior to the service of those foods to residents.
- Develop and implement quality management processes to monitor that the required food temperatures are monitored and recorded by staff serving foods to residents.
The order compliance date was July 29, 2016.

A review of the Cook's Production Daily Temperature Record- Main Kitchen revealed that during the period of the inspection, there were no temperatures measured and recorded for all potentially hazardous food items.

- A review of Cook's Production Daily Temperature Record- Main Kitchen for a specific menu during two months revealed there were no temperatures measured and recorded for all potentially hazardous food items during three occasions for lunch and dinner and eleven occasions for dinner.

Interview with Cook #152 and Cook #151 revealed that the food production temperature should be measured and recorded at all three meals breakfast, lunch and dinner on the above mentioned dates and meals.

- A review of Meal Service Daily Temperature Record for the Specific Menu for the specific floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on seven occasions at lunch, three occasions at dinner and two occasions no temperature recorded for all meals.

- A review of Meal Service Daily Temperature Record for the Traditional Menu for the second floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on two occasions for dinner and one occasion no temperature recorded for all three meals, record missing.

- A review of Meal Service Daily Temperature Record for the Specific Menu for the second floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on three occasions no temperature recorded for lunch, three occasions no temperature recorded for dinner, three occasions no temperature recorded for all meals.

- A review of Meal Service Daily Temperature Record for the Specific Menu for the third floor revealed there were no temperatures measured and recorded for all potentially hazardous food items on the five occasions no temperature recorded for lunch.

A review of the home's policy #CARE17-O20.02, entitled "LTC- Food Temperature Checklist", reviewed July 31, 2016, indicated temperatures are to be taken at the end of the cooking process and recorded under cooking temperature on the Cook's Meal Production Daily Temperature Record. Cook/Food Service Workers record the temperatures of the menu items for all diet types and textures immediately after taking temperatures and records on the Meal Service daily Temperature Record.

Interview with Dietary Aide #145, #146, #148, and Late Cook #147 confirmed that staff are expected to measure and record food temperatures for all food items for all meals during production and prior to serve meals to residents for both Traditional and Indian menus.

Interview with FSM confirmed that staff are expected to measure and record food temperatures for all food items and for all meals during production and prior to serving meals to residents for both Traditional and Indian Menus. FSM also confirmed that he/she does monitor staff measuring and recording food temperatures on a daily basis and if he/she finds any discrepancy he/she will communicate immediately with staff. The FSM was unable to explain the above mentioned missing entries for food temperatures in the specified period.

An interview with FSM, revealed that FSM monitors staff to ensure that they monitor and record temperatures on a daily basis however FSM was unable to present any tools used for monitoring and was unable to explain the missing entries of temperatures in food production and food service temperature log in the specified period.

A review of the home's quality management dietary related audits failed to reveal audits conducted to monitor that the required food temperatures are monitored and recorded by staff serving foods to residents. A review of the various kinds of dietary audits presented by the home did not include a criteria for observing staff or for monitoring and recording temperature.

The severity 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 a non-compliance with the Compliance Order (CO) despite Ministry of Health action.

The licensee is currently in non-compliance with s.72. (3), as a result of a failure to comply with the requirements listed in CO #002 in previous order which corresponds with inspection #2016_431527_007, compliance date July 29, 2016.
As a result of the home not complying with requirements of the order that was due on July 29, 2016, the order is being reissued. [s. 72. (3) (b)] (500)

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

Jul 27, 2017

Order # /
Ordre no : 002

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

Linked to Existing Order /
Lien vers ordre existant: 2016_431527_0007, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007, 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 the home shall protect residents from abuse by anyone and shall ensure that

residents are not neglected by the licensee or staff. The plan will include but not limited to the following:

1. Develop and implement a plan to ensure collaboration between the interdisciplinary staff (including but not limited to recreation program staff, BSO lead, registered nurses, psychogeriatrician and PRCP consultant) on the development and the implementation of the plan of care for residents, including resident #010, exhibiting inappropriate sexual behaviours including but not limited to inappropriately touching other residents in a sexual nature.

2. Develop and implement a plan to ensure residents exhibiting inappropriate behaviours including but not limited to inappropriately touching other residents are consistently monitored as per the plan of care and that the responsible staff member document, on the appropriate tool, according to the behaviour, as per the home's policies and the home’s flow sheet documentation system.

3. Develop and implement a plan to educate staff who are responsible for monitoring residents exhibiting inappropriate behaviours including but not limited to inappropriately touching other residents, on proper monitoring techniques, risks associated with not monitoring and the importance of and how to document. Dated proof of attendees, trainers and material taught to be kept by the home.

4. Develop and implement a plan to ensure internal reporting and referral process and external referral to specialized resources for residents exhibiting inappropriate behaviours including but not limited to inappropriately touching other residents are developed and implemented. The plan should include but is not limited to: defining the roles and responsibilities of all interdisciplinary team members in the assessment of the resident' exhibiting inappropriate behaviours including but not limited to inappropriately touching other residents, defining who is responsible for initiating referrals, a description of the protocol for communicating and sending the referral to the psychogeriatrician and/or PRCP consultant, a description of who will and how to take notes during consultation meetings with the psychogeriatrician and/or PRCP consultant, and who will and how the plan of care will incorporate recommendations and how interventions will be evaluated. The plan should include but is not limited to: registered staff in the assessment of

the resident, the reporting and referral process and communicating the outcomes of the BSO committee meetings to unit staff.

5. Develop and implement a plan for evaluation of the efficacy of treatment for residents exhibiting inappropriate behaviours including but not limited to inappropriately touching other residents with every change in treatment, medication or new intervention.

The plan to be submitted via email to slavica.vucko@ontario.ca by May 3, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On June 16, 2016, a Compliance Order (CO) #003 was issued as follows:
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 inspector.
The home was in compliance with requirements #1, 2, 3, 4.

The following non-compliance is related to two critical incident reports, one in 2016, and another one in 2017, alleging resident to resident abuse involving resident #012 and #010.

Resident #010 was admitted to the home on a specified date. Review of resident

#010's CCAC application noted resident's cognitive status was mildly impaired, with no behavioural issues identified.

According to the progress notes on a specified date one month after the admission, in evening time resident #010 was noted to exhibit socially inappropriate behaviour towards resident #013. According to the BSO PSW resident #010 touched resident #013 trying to comfort him/her, because he/she seemed sad. The same day another resident reported to the nurse that resident #010 was previously seen touching resident #013 (with severe cognitive impairment). An interview with ADOC revealed the resident who reported the touching was not able to give clear description of the nature of the touching. The reporting resident was discharged from the home and not interviewed by the inspector.

A review of the written plan of care revealed the section for responsive behaviour was revised to include that resident #010 is to be monitored to prevent him/her from touching other residents, staff to check the resident for safety every one hour. According to progress notes, after the incident, the resident was prescribed a specified medication, for treatment of inappropriate behaviour.

A review of the responsive behavior written plan of care after the incident, revealed the resident would do better on a 1:1 basis with activation and no group programs for the resident. The written plan of care did not include a section for recreation and leisure activities. A review of resident #010's recreation participation report for three months, revealed the resident participated in 13 group programs on multiple occasions. An interview with the Program Manager, revealed unawareness that resident #010 would do better with activities on a 1:1 basis as part of managing the responsive behaviour and he/she confirmed that the section for activities was missing in the written plan of care. The Program Manager updated the written plan of care with 1:1 activities during the inspection process, and included the department that was responsible for implementing.

On a later specified date, resident #010 was moved to another floor unit. A review of the written plan of care and progress notes revealed he/she was noticed taking another resident from his/her initial floor to his/her room on the new floor but they were separated in a timely manner by staff. The same period, the care plan was revised and 30 minute monitoring of resident #010 was initiated. Review of progress notes revealed the resident was on behaviour mapping, Dementia Observation System (DOS) and Antecedents-Behaviour-Consequences (ABC) model.

According to Physician's order, one month after the resident was moved to another floor, the medication for treating his/her innapropriate behaviour was decreased because the resident did not present with inappropriate behaviours. According to the care plan the 30 minutes monitoring remained in effect.

On a specified date resident #010 was observed by recreation staff in the unit TV area, beside the post, across the nursing station, to be standing in front of resident #012 and inappropriately touching the resident. According to the CI and progress notes the police, Substitute Decision Maker (SDM) and the Physician were notified and one to one monitoring was ordered. DOS observation was initiated for four days.

On a later specified date, an external consultant discontinued the one to one observation because the resident did not present with a similar behaviour but according to the written plan of care the 30 minute observation was still active.

On a specified date, the home's behavioural support Ontario (BSO) committee created an action plan for resident #010 to be involved in activity programs. Interview with BSO lead PSW revealed it was either her responsibility or the one to one staff to make sure the resident is involved in the activities, there was no documentation to support the evaluation of these activity programs as part of the behavioural support action plan.

On another specified date resident #010 was noted by a PSW in the sunroom to be standing in front of resident #012 exhibiting socially inappropriate behaviour. The residents were separated, police and SDMs were notified. The written plan of care was updated stating the resident was not supposed to go into the sun-room unsupervised.

On a later specified date, the Physician increased resident #010's medication for the inappropriate behaviour and ordered one to one monitoring. During the inspection resident #010 was still on one to one monitoring.

According to interview with Social Worker (SW), on a specified date, resident #012 was moved to another floor for his/her safety after the two incidents.

A review of resident #010's documentation 30 minute safety monitoring flow sheets for the period of three months, revealed missing documentation on twelve occasions

during different shifts. There was no set up for staff to document in the time period between 0330 hours (hrs) and 0730 hrs, and 90% of the documentation between 1430 hrs and 2230 hrs was missing. Interview with RAI Coordinator and DOC revealed there was a glitch in the Point of care (POC) documentation system and the set up for documentation is for staff who works from 0700 to 1500 hrs but the PSWs on 3rd floor work from 0600 hrs to 1400 hrs, and confirmed that for the period between 0330 hrs and 0730 hrs there was no set up for staff to document and for the second period between 1430 hrs and 2230 hrs most of the documentation was incomplete because the staff was leaving at 1400 hrs and 2200 hrs and in order to document for the time period after they leave or before they come they have to switch the assignment in the computer and confirmed they were not doing that.

According to the Care Pathway for Responsive Behaviour, part of the policy section for Dementia Care Care3-P10, dated July 31, 2016, stated if the behaviour is high risk and threatening to residents and/or staff and maybe unpredictable in nature, the staff has to ensure resident and staff safety, notify the physician, request 1:1, identify and document behaviour including specific description of behaviour (verbal, physical, aggressive, non-aggressive), start behaviour monitoring and continue a minimum of four days (all shifts). If the behaviour is not reduced or solved staff to consult appropriate resources: Psychiatrist, Psychologist, Geriatric Mental Health, Regional Manager Clinical Services (CNS), and implement recommendations. Further, under the tools for monitoring responsive behaviours there is an identified tool with 10 codes that describe the responsive behaviour to be monitored. Interview with DOC revealed the home did not use this tool for tracking resident #010's responsive behaviour but used the DOS tool because they considered it to be a type of responsive behaviour causing risk to other residents and they can use either tool.

Interviews with registered staff revealed that the process for assessing and referring a resident with responsive behaviour is as follows: when a resident presents with a responsive behaviour they document the behaviour and send a referral in the responsive behaviour binder to the BSO lead PSW who will further communicate with the Psychogeriatrician or the Psychogeriatric Resource Consultation Program (PRCP) consultant from the Toronto Outreach team. If it is urgent high risk behaviour the nurses will contact the home's physician. Interview with the BSO lead PSW revealed she is responsible for making sure the DOS and ABC model forms are initiated and filled out properly by staff and to communicate with the Psychogeriatrician. Interview with the home's educator revealed that the Psychogeriatrician and the PRCP consultant perform regular monthly visits to the

home; the Psychogeriatrician to perform assessments and the PRCP consultant to provide support with responsive behaviours and education to staff if needed. There is a paper form referral for the Psychogeriatrician from CAMH and the PRCP consultant is available by phone and email for urgent responsive behaviour support. The paper referral form for the Psychogeriatrician is available on the units and contact from the PRCP consultant is available only with the Educator and BSO Lead PSW.

According to interview with the home's educator the PRCP consultant did not come to the home on specified dates during two months, and according to the Social Worker interview he/she did not come because there was an outbreak in the home. The home was not able to provide evidence that the PRCP consultant was contacted after the incidents, for the incident between resident #010 towards resident #012 according to the home's policy for Responsive behaviour referrals to specialized resources.

Interview with the PRCP consultant revealed he/she does perform regular monthly visits to the home to provide education and support to staff for residents with responsive behaviour, and during the meetings the home has to present the case from the collected information, observation sheets, and progress notes. The home has to take notes from the consultation meeting and update the resident care plan accordingly with the interventions applied. He/she indicated he/she visited the home sometimes after the incidents but he was not presented with the incidents of resident #010, nor did the home's staff take notes from the consultation meeting. Further, he/she indicated he/she is accessible by phone and email for urgent consultations. He/she visited the home on a specified date two months after the incidents, and advised the home to involve the family in the resident responsive behaviour assessment and determining triggers. Certain facts about the resident the inspector was not able to locate in any clinical records or assessments of resident #010's responsive behaviour. He/she stated the resident would benefit from activities involving working with hands such as holding or folding towels.

The severity level was actual risk of harm, the scope of this non-compliance is a pattern as resident #010 poses a risk because he/she continued to exhibit inappropriate touching of residents and exposing him/herself in an inappropriate manner, there continued to be noncompliance with a Compliance Order (2017_405189_0003) and Compliance previously issued (2015_405189_0006, 2016_431527_0007, 2016_405189_0014 (A3)) in the last three years. [s. 19. (1)] (210)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Aug 27, 2017(A1)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s.101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12).

Order / Ordre :

The licensee shall provide education for all staff preparing meals and snacks related to preparation of the planned menu according to standardized recipes and production sheets and to keep up to date record for this education.

The education should include following:

- Date, title of the education, the material used for education, the mode of education, time period (number of hours) occupied for the education session, and the person who delivered the education
- Attendance sheet for staff who received the education with their name, title, and date when they received education
- Include all current full-time, part-time, casual, and new hire staff as of the compliance date who prepares meals and snacks
- Evaluate the effectiveness of this education by development and implementation of scheduled quality management system with formal documentation and record keeping

Grounds / Motifs :

1. The licensee has failed to comply with the following requirement of the Act: it is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts.

On June 16, 2016, a Compliance Order (CO) #001 was issued under s. 72. (2) as follows:
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 order compliance date was September 30, 2016.
The home was in compliance with requirements #1, 2, 4, 5, listed in the CO #001.

A review of the home's education record revealed the home failed to comply with requirement #3 listed in the CO #001. The home failed to provide education for staff preparing meals and snacks related to preparation of the planned menu according to standardized recipes/production sheets. The home presented a list of eight dietary staff signatures indicating education attendance, however, the list did not identify the education topic. The eight staff members were all involved in meal and snack preparation. Interview with staff did not reveal specific information about the topics of education.

Interview with FSM, DOC and ED were unable to provide a reason for not complying with the education requirement as indicated in the order. FSM and Staff Educator commenced this education after it was notified by the inspector, however it was conducted five month after the compliance date.

Although the severity level was minimum risk, scope is isolated within the home, and despite Ministry of Health action, there continued to be noncompliance with a Compliance order (CO) previously issued in the last three years. Currently the home is compliant with s. 72(2).

As a result of the home not complying with requirement #3 of the order due September 30, 2016, the order is being issued under s. 101. (3). (500)

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

Jul 27, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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

Director
c/o Appeals Coordinator
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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

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

Issued on this 9 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SLAVICA VUCKO - (A1)

Service Area Office /
Bureau régional de services : Toronto