Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 26, 2015	2015_380593_0019	S-000877-15, S-000923-15, 14284-15, 004004-15, 007786-15	Complaint

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

GILLIAN CHAMBERLIN (593), JENNIFER KOSS (616), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 27 - 31, 2015.

Additional non-compliance was found related to this complaint inspection under s.6 Plan of Care. This non-compliance has been captured in the follow-up inspection report which was undertaken concurrently with the complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Services Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Personal Support Workers (PSW), residents and family members.

The inspectors observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **2 VPC(s)**
- **1 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. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector reviewed resident #002's electronic Treatment Administration Record (e-TAR) for a five month period related to an order for a skin and wound treatment. There was an additional note indicating that a particular treatment was to be held because of a medical condition. Progress notes were reviewed skin care focus identified the resident's ongoing altered skin integrity until the last documentation which indicated "healed".

#S-104 reported that resident #002 had a treatment and was required to have a weekly assessment, documented in the resident's electronic progress notes. #S-104 reported knowledge of the treatment ordered for the resident's affected area. In addition, during an interview with #S-113 confirmed weekly treatment assessments were expected, and

occur on Tuesdays each week. #S-113 further added that all Registered staff were aware that Tuesdays are "wound care day" for weekly assessments or treatments. They stated there was no prompt, alert or reminder set up for this resident for staff to complete the task. If the assessment was not completed on Tuesday, it was not completed at all.

The ADOC confirmed that the home's expectation of Registered staff as per policy LTC-E-90 (March 2014) which notes that "all residents exhibiting altered skin integrity will be assessed by the Nurse on initial discovery and re-assessed with every dressing change but at a minimum of weekly. #S-102 added that the expectation is that staff complete weekly skin assessments on Tuesdays and this should be prompted on the resident's e-TAR. The assessment is documented as a progress note in the resident's electronic health record.

#S-102 reported they were unaware, clarifying they, as the home's Wound Care Champion, had not received a referral from staff, regarding any ongoing alterations to skin integrity since resident #002's skin condition appeared. Inspector reviewed a copy of the electronic progress notes with a Skin Care focus and confirmed weekly assessments were due on 19 dates in the period reviewed. Progress notes related to Skin Care were documented on 17 dates during this review period. With this information, #S-102 confirmed weekly skin assessments had not been completed for resident #002.

Resident #002 exhibited altered skin integrity and was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that the resident who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required and while asleep if clinically indicated.

A review of resident #001’s current care plan found that the resident had altered skin integrity and the interventions listed to manage this included: to turn every two hours, follow the turning and repositioning schedule and to complete the documentation for repositioning.

On Day A of the inspection, Inspector #593 observed resident #001 to be in the same position as observed for the past two hours. The repositioning flow sheet was last completed at 1400h, when the resident was repositioned. At 1645h, the resident was still observed to be in the same position. A review of the flow sheets the following day, found that the document was completed indicating that the resident was repositioned at 1600h.

On Day B of the inspection, Inspector #593 observed resident #001. The repositioning flow sheet indicated that the resident was last repositioned at 1300h. At 1650h, the inspector observed resident #001 to be in the same position as observed earlier. A review of the flow sheets the following day, found that the document was completed indicating that the resident was repositioned at 1500h.

On Day C of the inspection, Inspector #593 observed resident #001. The flow sheet indicated that they had been in this position since 0500h. At 1020h, the inspector reviewed the repositioning flow sheets and found that the flow sheet was signed indicating that the resident was repositioned at 0800h, however the document indicated that the resident was repositioned, which was the same position they were repositioned to at 0500h.

During an interview with Inspector #593 July 31, 2015, #S-110 reported that resident #001 was to be repositioned every two hours and that they were required to reposition them to relieve the pressure on the area with altered skin integrity. They added that they were required to complete the flow sheets once they had repositioned the resident.

A review of the home's Policy: Index-LTC-E-90 Revera Skin and Wound Care Program dated March 2014, found that residents who are unable to reposition themselves while sitting up or while in bed, even if they are on a therapeutic surface, will be repositioned by staff at a minimum of every two hours or more frequently as required depending on residents condition.

As observed by Inspector #593, resident #001 was not repositioned on numerous occasions during the inspection as required in the care plan. As such, the licensee has failed to ensure that the resident who is dependent on staff has been repositioned every two hours.

Non-compliance was previously identified under inspection 2012_053122_0014, including a compliance order served October 15, 2012, pursuant to O.Reg. 79/10, r. 50. (2) (b) (iv) Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and r. 50. (2) (d) Every licensee of a long-term care home shall ensure that, any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions.

In a complaint received by the Director it was stated that resident #006 was witnessed in an altercation with resident #007, and that resident #006 was observed to exhibit responsive behaviours frequently.

The inspector reviewed Resident Incident Internal Report forms from 2013 to 2015, and identified 12 completed forms involving resident #006 that documented incidents of verbal and physical responsive behaviours, including an incident between resident #006 and resident #007. It was documented that resident #007 sustained an injury after resident #006 exhibited physical responsive behaviours toward this resident. This incident was not reported to the Director.

Inspector #594 reviewed resident #006's health care record. Review of progress notes from 2013 until 2015 identified a documented pattern where the resident was identified in various resident to staff altercations where the resident initiated the altercations. The

inspector also identified a pattern of altercations between resident #006 and another resident; resident #020 commencing in October 2013.

Numerous altercations were identified between resident #006 and resident #020, beginning in 2013. A summary of the documented progress notes was as follows:

Day A: Staff approached resident #006 as they were crying out, after an unwitnessed altercation between the residents #006 and #007. An injury was sustained as a result.

Day B: Resident #006 exhibited responsive behaviours toward resident #020. Resident #006 then left resident #020's room and entered the lounge area, where they further exhibited responsive behaviours.

Day C: Resident #006 was exhibiting verbally responsive behaviours toward another resident. Resident #006 was initiating behaviours toward resident #020.

Day D: Resident #006 became physically aggressive with resident #020. Resident #006 also observed to be the initiator at times throughout the shift with behaviours aimed at resident #020.

Day E: Resident #006 attended activity in good spirits until they observed resident #020 and became physically responsive.

Day F: Resident #006 displaying physical responsive behaviours toward resident #020 while in the lounge area. Resident #006 was seeking resident #020.

Day G: Resident #006 displaying physical responsive behaviours toward resident #020. According to the progress note it was stated that interventions need to be an option as it was difficult for staff to continue to keep both residents apart and from being physically responsive. This was disturbing and scaring all other residents.

Day H: Resident #006 entered resident #020's room while resident #020 was going to bed. Resident #006 had been displaying verbal and physical responsive behaviours toward resident #020.

Day I: Resident #006 in two altercations with resident #020 prior and after dinner.

Inspector #594 reviewed resident #006's care plan focus which documented multiple

responsive behaviours. There were several care plan interventions addressing the behaviours.

A completed Resident Assessment Protocol (RAP), documented that the resident continued to be verbally and physically reponsive towards staff and co residents, that their behaviours were not easily altered by staff interventions; there were no referrals at this time for additional behavioural management services and staff were to monitor for any changes and report to MD as necessary.

During an interview with Inspector #594, #S-114 stated that resident #006 was known to have altercations with resident #007 and staff were aware to keep these residents apart. During an interview with Inspector #594, #S-110 stated that resident #006 and #007 were to be kept apart, and that resident #006 and resident #020 were also to be kept apart.

During an interview with Inspector #594, the DOC stated that resident #020 was a trigger for resident #006, and there was risk of interactions in the home as their rooms were in the same home area. According to the DOC, they did not believe it necessary to move either resident to another room or level of the home. The DOC further indicated that they had difficultly minimizing altercations between resident #020 and resident #006. When a staff member was in the lounge with both residents, there were no altercations, when resident #006 was occupied with activities, there were no altercations.

As evidenced by progress notes, internal incident reports and staff interviews, resident #006 was known to demonstrate responsive behaviours towards staff for multiple years and towards other residents for a period of at least nine months. The home was aware of these behaviours and staff were aware to keep the residents #006 and #020 apart, however this did not occur consistently and as a result the altercations continued. [s. 54. (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 ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents including identifying and implementing interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

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

On July 29, 2015 at 0900h, Inspector #593 observed the insulated tray cart on one of the home area's. The cart was used to transport the breakfast tray meals for residents receiving tray service. At 0923h, the inspector observed one of the trays with a full meal and a plate cover on the counter in the nurses' station; the breakfast was observed to include a hot breakfast. The tray ticket indicated that it was resident #013's breakfast tray. This tray was observed to stay on the counter in the nurses' station until 1011h, more than one hour since the tray meals were first observed in this area.

During an interview with Inspector #593 July 29, 2015, #S-106 reported that resident

#013 is not ready for breakfast until later. They added that the resident's breakfast tray is not kept in the insulated cart as the dietary staff will collect this and take it back to the kitchen shortly after breakfast. #S-106 further reported that the tray remains in the nurses' station until the resident is ready for breakfast; they will then heat the meal in the microwave and serve it to the resident.

On July 30, 2015 at 0900h, Inspector #593 observed the insulated tray cart on one of the home area's. The cart was used to transport the breakfast tray meals for residents receiving tray service. A PSW was observed to take a meal from the cart and leave it on the counter in the nurses' station, 12 minutes later, they took the meal to a resident on the unit. At 0930h, resident #001 was provided a meal, at least 30 minutes after the tray meals were first delivered to one of the home area's from the kitchen. The meal was not reheated during this time.

On July 30, 2015 at 1145h, Inspector #594 observed a cart with the lunch tray meals on one of the home area's. Inspector #593 observed that these same meals were not provided to residents in this area until 1230h when resident #001 was observed to receive the first tray meal, 45 minutes after the meals were first delivered from the kitchen. The meals were not kept warm during this time, nor did the staff reheat the meals before serving.

On July 31, 2015 at 1140h, Inspector #593 observed a cart with four tray meals on one of the home area's. At 1215h, the inspector observed a PSW to serve one of the meals to a resident in this area. At 1230h, the inspector observed a PSW provide a tray meal to resident #001, 40 minutes after the inspector first observed the meals in this home area. The meals were not kept warm during this time, nor did the staff reheat the meals before serving to the residents.

During an interview with Inspector #593 July 31, 2015, #S-107 reported that it can vary as to how soon the resident receives the tray meal after they are delivered from the kitchen. If the residents are required to be fed, then some meals will be held until the first residents are fed by the PSWs and then they can move on to provide assistance to the next residents. If the unit is short staffed, which does happen often, the tray meal will usually sit there until there is a staff member available to assist the resident. They further added that quite often the meals will sit for 30 minutes before they are served to the residents. #S-107 reported that they do have a microwave available to reheat meals, however some foods like toast and oatmeal do not reheat well.

During an interview with Inspector #593 August 5, 2015, the Food Service Manager (FSM) reported that the expectation with tray service is that the meals should be served immediately to the residents and not left sitting on the cart. He further advised that it is not acceptable that the meals are left sitting for up to 45 minutes before being served to the residents. Furthermore not all of the tray meals are delivered in an insulated cart as the home only has two of these, so the tray meal requirements will often exceed the amount the insulated carts can hold and therefore they have to use the regular carts to transport meals, and these are not insulated.

A review of the home's Policy- Tray Service Referral, found that when providing residents with tray service, they must be mindful of all aspects of meal service such as; food safety and sanitation, staffing levels, available equipment and pleasurable dining.

Inspector #593 observed on numerous occasions, a lengthy delay in the tray meals being served to residents from the time they were delivered from the kitchen to the unit. The meals were not kept warm during this delay nor were they reheated prior to consumption by the residents. This delay in serving the meals will affect the temperature of the meals, affecting the safety and the palatability of the meals. [s. 73. (1) 6.]

2. The licensee has failed to ensure that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance.

On July 29, 2015, Inspector #593 observed #S-108 feeding resident #016. The resident was observed to be seated with a positioning device applied and #S-108 was standing beside the resident while assisting them with feeding.

On July 29, 2015, Inspector #593 observed #S-108 feeding resident #017 a beverage from the afternoon nourishment pass. The resident was observed to be seated with a positioning device applied and #S-108 was standing beside the resident while assisting them with drinking the beverage.

On July 30, 2015, Inspector #593 observed #S-110 feeding breakfast to resident #017. #S-110 was observed to be standing over the resident while assisting them with eating.

On July 31, 2015, Inspector #593 observed #S-105 feeding breakfast to resident #016. The resident was observed to be in bed and the bed was raised however the resident was reclined back and therefore not sitting upright. #S-105 was observed to be standing over the resident while spooning the food into their mouth.

During an interview with Inspector #593 July 31, 2015, #S-111 reported that to ensure a safe feeding experience, the resident needs to be upright and the staff member should be seated at the same height as the resident. They added that they do not have a lot of choice with the chairs that are provided for feeding, and that there are adjustable feeding stools, however these are difficult to locate within the home.

A review of resident #016's current care plan found that the resident has specific interventions to address this to ensure safe feeding.

A review of resident #117's current care plan found that the resident has specific interventions to address this to ensure safe feeding.

Inspector #593 observed on numerous occasions, staff members within the home providing feeding assistance to residents at a high risk of choking, failing to use proper techniques to assist residents with eating, including safe positioning of residents who require assistance. [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 ensuring that all food served is served at a temperature that is both safe and palatable to the residents and that proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #4: 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 the home's Policy: LTC-F-20 Medication Administration dated August 2012, is complied with.

A review of resident #001's Medication Administration Record (MAR) found that the resident was to receive oral nutrition supplements at the medication pass.

On July 28, 2015 at 1504h, Inspector #593 observed an opened carton of a specific oral nutrition supplement on resident #001's bedside. None of this supplement had been consumed by the resident. A review of the MAR found that #S-109 had signed off that supplement had been administered.

On July 30, 2015 at 1028h, Inspector #593 observed a cup of a specific oral nutrition supplement on resident #001's bedside. The cup was full at this time. Inspector continued to observe the resident for the next two hours. At no point during this two hours, was the resident offered the specific oral nutrition supplement or any other supplements and at 1210h, the supplement was still observed to be sitting at the bedside. A review of the MAR found that #S-109 had signed off that the oral nutrition supplement had been administered during this period.

A review of the home's policy: LTC-F-20 Medication Administration dated August 2012, found that the medication must be observed for ingestion otherwise it cannot be considered administered and all medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by the administering nurse. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's Policy: Index-LTC-E-90 Revera Skin

and Wound Care Program dated March 2014, is complied with.

A review of resident #001's current care plan found that the resident had altered skin integrity and the interventions listed to manage this included: to follow the turning and repositioning schedule and to complete the documents at the bedside for repositioning.

On Day A of the inspection, Inspector #593 observed resident #001 to be in the same position as observed for the past two hours. The repositioning flow sheet was last completed at 1400h, when the resident was repositioned. At 1645h, the resident was still observed to be in the same position. A review of the flow sheets the following day, found that the document was completed indicating that the resident was repositioned at 1600h.

On Day B of the inspection, Inspector #593 observed resident #001. The repositioning flow sheet indicated that the resident was last repositioned at 1300h. At 1650h, the inspector observed resident #001 to be in the same position as observed earlier. A review of the flow sheets the following day, found that the document was completed indicating that the resident was repositioned at 1500h.

On Day C of the inpsection, Inspector #593 observed resident #001. The flow sheet indicated that they had been in this position since 0500h. At 1020h, the inspector reviewed the repositioning flow sheets and found that the flow sheet was signed indicating that the resident was repositioned at 0800h, however the document indicated that the resident was repositioned, which was the same position they were repositioned to at 0500h.

A review of the home's Policy: Index-LTC-E-90 Revera Skin and Wound Care Program dated March 2014, indicated that residents who are unable to reposition themselves while sitting up or while in bed, even if they are on a therapeutic surface, will be repositioned by staff at a minimum of every two hours or more frequently as required depending on residents condition. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's Policy: Index-LTC-G-50 Nutrition Care Referral dated October 2014, is complied with.

During an interview with Inspector #593 August 4, 2016, the home's Registered Dietitian (RD) reported that when resident #002's when resident #002 experienced a change in their nutritional intake they were not referred to the RD to assess this resident and they did not complete a nutrition assessment as a result of this change in the resident's

condition affecting nutritional status.

A review of the home's Policy: Nutrition Care Referral Index-LTC-G-50 dated October 2014, found that a hand-written referral or an electronic referral in Point Click Care (PCC) will be made to the Registered Dietitian (RD) with any significant change in the residents' health affecting nutritional status and the RD will document any changes in the interdisciplinary progress notes and in the resident's Care Plan. [s. 8. (1)]

4. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system is in compliance with and is implemented in accordance with applicable requirements under the Act; and is complied with.

The inspector reviewed the home's Pain Assessment and Symptom Management policy (LTC-E-80-revised date August 2012) for reference to staff education, finding none. An interview with the ADOC, they confirmed the policy did not identify which staff would receive education and training or the frequency of that education.

The policy does not set out that annual training shall be provided to all staff who provide direct care to residents related to pain management. [s. 8. (1) (a),s. 8. (1) (b)]

WN #5: 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 has failed to ensure that every witnessed incident of abuse of a resident by anyone, is immediately investigated. During a review of resident #007's health care record by Inspector #594, it was documented that the resident sustained an injury after resident #006 displayed responsive behaviours toward resident #007.

In a statement received by the Inspector from the DOC, it was stated that there were no investigation notes pertaining to the event. [s. 23. (1) (a)]

2. The licensee has failed to ensure that every witnessed incident of abuse of a resident by anyone, is immediately investigated. The inspector reviewed Resident Incident Internal Report Form's from 2013 to 2015. Included in these forms was a hand written description from a direct care staff member who stated a student witnessed resident #020 display responsive behaviours toward resident #006 resulting in an injury.

In a statement received by Inspector #594 from the DOC, it was stated that there were no investigation notes pertaining to the event.

Review of the home's Resident Non-Abuse - Ontario policy #LP-C-20-ON revised September 2014 stated an immediate and thorough investigation of the reported alleged, suspected or witnessed abuse will be initiated by the Home's ED/designate. [s. 23. (1) (a)]

WN #6: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a nutritional assessment was completed for resident #002 when there was a significant change in the resident's condition affecting nutritional intake.

During an interview with Inspector #593 August 4, 2015, the home's Registered Dietitian (RD) reported that when resident #002 experienced a change in their nutritional intake they were not referred to the RD to assess this resident and they did not complete a nutrition assessment as a result of this change in the residents condition affecting nutritional intake.

A review of the home's Policy: Nutrition Care Referral Index-LTC-G-50 dated October 2014, found that a hand-written referral or an electronic referral in Point Click Care (PCC) will be made to the Registered Dietitian (RD) with any significant change in the residents health affecting nutritional status and the RD will document any changes in the interdisciplinary progress notes and in the Residents Care Plan.

A review of resident #002's current care plan found that they required specific nutrition interventions. The interventions included providing a specific nutritional supplement at certain times over the day.

A review of resident #002's progress notes found that the RD had last assessed the resident four months earlier.

A review of resident #002's progress notes identified the following:

Day A: a change occurred in the resident's health which affected their nutritional intake. As a result the resident did not receive adequate nutrition over a four day period. The resident was not referred to the Registered Dietitian.

Day B: a change occurred in the resident's health which affected their nutritional intake. As a result the resident did not receive adequate nutrition over a two day period. The resident was not referred to the Registered Dietitian. [s. 26. (4)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 and all other residents of the home were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A review of the home's Daily Missed Baths record from March 2015 to July 28, 2015 indicated that on a specific day, due to being "short-staffed", resident #002 missed their regularly scheduled evening bath. For the evening of a second date in this period, data was incomplete regarding the status of resident's missed baths. To determine whether resident #002 received their regularly scheduled bath on this date, Inspector spoke with #S-115 on July 30, 2015. #S-115 accessed the resident's POC record for the specific date, noting the task was in red, which #S-115 confirmed meant the task was "overdue", further clarifying that it had not been done. #S-112 was asked to provide a POC bathing task completion report for resident #002, and could not provide any further information as there was no completed task for this date. [s. 33. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening.

The Inspector reviewed resident #001's focused "Oral Hygiene" report for a one month period provided by #S-112 which stated oral hygiene to be done at a specific schedule over the day. The response "Resident refused" was documented 15 times and there were four dates where no documentation was entered related to the provision of oral hygiene. Time stamped entries from PSW data entry on the resident's POC were inconsistent with the times expected to correlate to care provided in the morning, evening and after meals.

#S-110, PSW stated oral care is provided to the resident every a.m and each meal, evening shift would do the same, adding that the resident frequently refuses care on average one-two shifts per day but can try other staff if they continue to refuse. The ADOC stated that the home's policy was to provide oral care two times per day to residents. Resident #001's current care plan indicated the resident required assistance with mouth care. The ADOC clarified the POC time stamped entries were to be documented at the time of care provided and would therefore expect time stamped entries at a minimum 5 times a day. The ADOC confirmed that oral care was not provided to resident #001 as per plan of care.

On the dates POC documentation notes "resident refused", the ADOC reported they would expect staff to try 2-3 times, sometimes with other staff and if still unsuccessful to document why the care was not provided. A review of POC documentation for a period of one month, indicated that the resident refused oral care on 15 occasions. Progress notes were reviewed for corresponding dates of resident refusal of oral care finding no documentation related to care not provided. The ADOC indicated that the resident had not received oral care at least two times per day.

Resident #001 did not receive oral care to maintain the integrity of the oral tissue that includes mouth care in the morning and evening and after each meal as per plan of care. [s. 34. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training shall be provided to all staff who provide direct care to residents related to pain management, including pain recognition of specific and non-specific signs of pain.

During interviews with #S-106, #S-110, #S-116 and #S-117, they all reported they had not received education regarding pain management.

During an interview with the DOC, they reported that only Registered staff receive pain management training and evaluation using the Faces tool. Further, the DOC could not recall when the last training session was held and stated that it is supposed to be every two years. They also stated that PSWs do not receive pain management education. During an interview with the ADOC, they confirmed that the PSWs do not receive pain management education and the home could not provide education records as this was not completed.

Training has not been provided to all staff who provide direct care to residents related to pain management, including pain recognition of specific and non-specific signs of pain. [s. 221. (1) 4.]

Issued on this 15th day of September, 2015

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

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GILLIAN CHAMBERLIN (593), JENNIFER KOSS (616), MONIKA GRAY (594)
Inspection No. / No de l'inspection :	2015_380593_0019
Log No. / Registre no:	S-000877-15, S-000923-15, 14284-15, 004004-15, 007786-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 26, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

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. 50. (2) Every licensee of a long-term care home shall ensure that,

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

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

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

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

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

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

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

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s.50 (2) of the Regulations. This plan is to include:

* Implementation /Re-implementation of a system ensuring that residents exhibiting altered skin integrity are re-assessed at least weekly by a member of the registered nursing staff.

* A retraining schedule for registered nursing staff on the skin and wound program including regular skin and wound assessments.

* A retraining schedule for direct care staff on repositioning requirements of residents and documentation expectations.

This plan may be submitted in writing to Long-Term Care Homes Inspector Gillian Chamberlin at 346 Preston Street, Level 4, Ottawa, Ontario, K1S 3J4. Alternatively, the plan may be e-mailed to the inspector at gillian.chamberlin@ontario.ca. This plan must be received by September 9, 2015 and fully implemented by September 23, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector reviewed resident #002's electronic Treatment Administration Record (e-TAR) for a five month period related to an order for a skin and wound treatment. There was an additional note indicating that a particular treatment was to be held because of a medical condition. Progress notes were reviewed skin care focus identified the resident's ongoing altered skin integrity until the last documentation which indicated "healed".

#S-104 reported that resident #002 had a treatment and was required to have a weekly assessment, documented in the resident's electronic progress notes. #S-104 reported knowledge of the treatment ordered for the resident's affected area. In addition, during an interview with #S-113 confirmed weekly treatment assessments were expected, and occur on Tuesdays each week. #S-113 further added that all Registered staff were aware that Tuesdays are "wound care day" for weekly assessments or treatments. They stated there was no prompt, alert or

reminder set up for this resident for staff to complete the task. If the assessment was not completed on Tuesday, it was not completed at all.

The ADOC confirmed that the home's expectation of Registered staff as per policy LTC-E-90 (March 2014) which notes that "all residents exhibiting altered skin integrity will be assessed by the Nurse on initial discovery and re-assessed with every dressing change but at a minimum of weekly. #S-102 added that the expectation is that staff complete weekly skin assessments on Tuesdays and this should be prompted on the resident's e-TAR. The assessment is documented as a progress note in the resident's electronic health record.

#S-102 reported they were unaware, clarifying they, as the home's Wound Care Champion, had not received a referral from staff, regarding any ongoing alterations to skin integrity since resident #002's skin condition appeared. Inspector reviewed a copy of the electronic progress notes with a Skin Care focus and confirmed weekly assessments were due on 19 dates in the period reviewed. Progress notes related to Skin Care were documented on 17 dates during this review period. With this information, #S-102 confirmed weekly skin assessments had not been completed for resident #002.

Resident #002 exhibited altered skin integrity and was not reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]
(616)

2. The licensee has failed to ensure that the resident who is dependent on staff for repositioning has been repositioned every two hours or more frequently as required and while asleep if clinically indicated.

A review of resident #001's current care plan found that the resident had altered skin integrity and the interventions listed to manage this included: to turn every two hours, follow the turning and repositioning schedule and to complete the documentation for repositioning.

On Day A of the inspection, Inspector #593 observed resident #001 to be in the same position as observed for the past two hours. The repositioning flow sheet was last completed at 1400h, when the resident was repositioned. At 1645h, the resident was still observed to be in the same position. A review of the flow sheets the following day, found that the document was completed indicating that the resident was repositioned at 1600h.

On Day B of the inspection, Inspector #593 observed resident #001. The repositioning flow sheet indicated that the resident was last repositioned at 1300h. At 1650h, the inspector observed resident #001 to be in the same position as observed earlier. A review of the flow sheets the following day, found that the document was completed indicating that the resident was repositioned at 1500h.

On Day C of the inspection, Inspector #593 observed resident #001. The flow sheet indicated that they had been in this position since 0500h. At 1020h, the inspector reviewed the repositioning flow sheets and found that the flow sheet was signed indicating that the resident was repositioned at 0800h, however the document indicated that the resident was repositioned, which was the same position they were repositioned to at 0500h.

During an interview with Inspector #593 July 31, 2015, #S-110 reported that resident #001 was to be repositioned every two hours and that they were required to reposition them to relieve the pressure on the area with altered skin integrity. They added that they were required to complete the flow sheets once they had repositioned the resident.

A review of the home's Policy: Index-LTC-E-90 Revera Skin and Wound Care Program dated March 2014, found that residents who are unable to reposition themselves while sitting up or while in bed, even if they are on a therapeutic surface, will be repositioned by staff at a minimum of every two hours or more frequently as required depending on residents condition.

As observed by Inspector #593, resident #001 was not repositioned on numerous occasions during the inspection as required in the care plan. As such, the licensee has failed to ensure that the resident who is dependent on staff has been repositioned every two hours.

Non-compliance was previously identified under inspection 2012_053122_0014, including a compliance order served October 15, 2012, pursuant to O.Reg. 79/10, r. 50. (2) (b) (iv) Every licensee of a long-term care home shall ensure that, a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; and r. 50. (2) (d) Every licensee of a long-term care home shall ensure that, any resident who is

dependent on staff for repositioning is repositioned every two hours or more frequently as required. [s. 50. (2) (d)] (593)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 23, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 26th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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