Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 29, 2014	2014_246196_0006	S-000130-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

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

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

LAUREN TENHUNEN (196), KARI WEAVER (534), MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 7, 8, 9, 10, 11, 14, 15, 16, and 17th, 2014

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (DOC), Regional Manager of Clinical Services, Assistant Director of Care (ADOC), Environmental Services Manager (ESM), Food Service Manager (FSM), Recreation Manager, Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, RAI Coordinator and RAI Backup staff member, Resident Counsellor, dietary staff, maintenance staff, staff scheduler, residents and family members.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed the provision of care and services to residents, observed the staff to resident interactions, reviewed the health care records for several residents, reviewed numerous licensee policies and procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Quality Improvement
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The care plan document for resident #459 was reviewed by inspector #106. It indicated that the resident is to have their bed in the lowest position while in bed. On two days in April 2014, the inspector observed the resident in bed and the bed was not in the lowest position. On another day in April 2014, a PSW told the inspector that the resident has a hand held remote for their bed and will raise the bed up. The PSW also told the inspector that the resident prefers to have a rolling side table, positioned so the table top is across their abdomen and to have the table in this position the bed cannot be in the lowest position.

The licensee failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

2. The inspector reviewed the RAI-MDS for resident #491. Changes in RAI-MDS pain documentation were noted to have started January 2014 with documented daily, moderate headache pain. The subsequent RAI-MDS in early April 2014 continued to document daily moderate back pain for the resident. According to staff member #108 and the progress notes in the chart, the resident had sustained a fall with resulting

back and shoulder pain in March 2014.
Staff members #112, #108, #109, and #111 conveyed to inspector #534 that the home's staff, use and document resident pain using the home's paper flow sheet entitled "Pain Monitoring Sheet LTC-E-80-10-ON Aug.2012". On a particular day in April 2014 the inspector requested the pain monitoring sheets for resident #491 from staff member #108 for the time period when RAI-MDS had assessed and documented changes in the resident's pain as daily. Neither the inspector nor staff member #108 could locate pain monitoring sheets for the resident from January 2014 through to April 2014. Staff member #108 stated this was because the resident only received prescribed and PRN (as required) doses of analgesia and not narcotic pain medications, which would require staff to use the monitoring sheets.
Staff member #112 was interviewed on a day in mid April 2014 concerning resident #491's pain level changes. Staff member #112 stated that the resident has no real complaints of pain but will communicate pain by pointing to body areas or when staff members notice a change in behaviour, for example, increased agitation could indicate pain. This staff member then reported that staff do not routinely ask residents if they are experiencing pain unless they know a resident is currently having problems.

Recent SALT (Safe Ambulation Lifts and Transfer) assessments from two days in March 2014 identified resident #491 as having "pain" under the physical functioning status heading. Inspector #534 reviewed the resident's eMAR records for PRN pain medication administration starting in January 2014 to mid April 2014 and noted the resident received twenty-six PRN doses of pain medication. Additional progress notes related to pain for the resident were noted on three consecutive days at the end of March 2014. Two care plans for resident #491 were reviewed by the inspector with dates of February 2014 and April 2014. Neither care plans identified this change in pain status for the resident nor contained any foci, goals, or interventions related to pain.

The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. [s. 6. (2)]

3. The progress notes for resident #491 were reviewed, and it was noted that the resident had an unwitnessed fall on a particular night shift in March 2014, while the resident was in the bathroom about to sit on the toilet seat.
During day time observations of resident #491, inspector #534 noted the resident to have proper footwear, call bell within reach, and their walker positioned beside the resident's bed. No transfer logo was noted above the resident's bed to identify the

level of staff assistance that the resident required for transferring. During an interview in mid April 2014, staff #112 reported that resident #491 is independent with transfers, knows how to use the brakes on the walker so they can sit down and take rests as needed, and is "self-aware" for asking for staff assistance when transferring and ambulating. Staff member #108 confirmed that the resident is a "1 person supervised transfer" and often times the resident gets up on their own and won't ring the call bell for assistance and does not use a bed alarm for night.
The most recent "SALT-Assessment Form for Lifts and Transfers" dated the end of March 2014 identifies resident transferring as "one person supervised-minimum assistance with verbal cueing is required" for day, evening, and night shifts and uses a 4 wheeled walker for ambulation. Staff member #108 provided the latest "Fall Risk Assessment Tool-FRAT" and it identified the resident as low risk for falls and reported that a post fall FRAT was not completed. The resident's RAI-MDS dated early April 2014 identifies the resident has an "unsteady gait", requires partial physical support or doesn't follow directions for balance testing while standing, and for self-transferring and toileting requires limited help of 1 person physical assistance.
The resident's care plan identified conflicting transferring interventions in various areas of the care plan and this was confirmed with staff member #108. Under the focus heading of risk for falls, interventions outline that resident uses a wheeled walker with one staff to cue and that the resident will get up and walk in room without supervision; under the transferring focus the care plan lists that the resident requires supervision or cues of one staff to transfer safely using a wheeled walker; and under the focus of toileting, interventions list resident will toilet self without staff assistance. Interventions do not clearly outline the resident's need for one person physical assistance for transferring and toileting as identified in the resident's assessments.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4). [s. 6. (4)]

4. On a particular morning in April 2014, it was reported to the inspector that resident #708 had a fall out of bed. According to staff member #113, the bed alarm was not on the resident's bed as it had been removed and was waiting for a battery and therefore it hadn't activated. Management staff member #109 confirmed to the inspector that the alarm had been taken off the bed on the night shift and was awaiting a battery change. The current care plan with a focus of "high risk for falls" was reviewed and included the intervention of "bed alarm is used". On a particular day in April 2014,

resident #708 did not have a bed alarm in use as was included in the plan of care.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

5. A Critical Incident System report was submitted to the Director in December 2013 for an incident that caused an injury for which resident #601 was taken to hospital and which resulted in a significant change in their health status.
The progress notes for resident #601 were reviewed and identified that the resident had fallen sometime during the night shift in December 2013 but was not reported by the night shift staff. Staff member #115 documented that on the night shift a support staff worker had assisted the resident up to the toilet and left the resident unattended for "a minute" and it was during this time period the resident attempted to get themselves off the toilet when the injury occurred. The information that was documented by staff member #115 had been obtained from the resident. When the resident was seen and assessed by the RPN in the morning it was noted that the resident's had an injury and the RN was called to assess. In the resident care plan that was in place prior to the fall, interventions are noted that when the resident is toileted that staff are to remain with the resident to ensure the resident remains seated. According to the progress notes, the night shift support person did not stay with the resident when the resident was toileted despite the clear directions in the care plan directing staff to stay with the resident.

The home failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

6. Resident #459 was moved to another unit to allow access to their room for renovations. An interview was conducted with staff member #114 on the unit the resident was moved to, regarding the resident's care needs and the location of the plan of care. Inspector #196 was unable to locate a copy of the current care plan and kardex as there wasn't one in the plan of care binder in the cupboard in the nursing station on this unit. Staff member #114 reported that they were not sure where the care plans were and told the inspector that they had heard of a kardex but hadn't seen one before. When asked where they would get information about the care that this resident was to receive, they said they would ask other staff and look at the signs above the resident's bed. This same staff member then opened resident #459's chart and stated "would look at the..." and pointed to the admission record sheet for information about the resident.

The care plan and kardex for this resident was found by the inspector in the plan of care binder on the original unit that the resident had resided, prior to the move. As a result, direct care staff did not have access to resident #459's plan of care, specifically the care plan and kardex.

The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. [s. 6. (8)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the plan of care for resident #459 and #491 is based on an assessment of the resident and the resident's needs and preferences, and ensures that the staff and others involved in the different aspects of care of resident #491 collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and that staff and others who provide direct care to resident #469 are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. On a particular day in April 2014, the inspector spoke with staff member #101 and it was determined that they were the only staff on the unit to provide care for approximately 25 residents. The other PSW was in the main floor dining room assisting with meal service from 1230hrs through to 1400hrs and the RPN had been called to attend to another unit. [s. 8. (1)]

2. On another evening in April 2014, a visiting family member sitting in the common area of one of the units mentioned to the inspector that they had not seen any staff in the previous twenty minutes. The family member's relative was not in any need of assistance, just was concerned that no staff were around. Inspector #196 did a walk through of the unit at that time and spoke with staff member #102 who confirmed that they were the only staff member on the unit because of the other staff members assisting with dining service on the main floor and having their meal breaks.
A short time later, resident #704 was observed lying on their back, on the floor in their room with staff member #102 present. According to this staff member, the resident had fallen out of the bed and that the RN has been called to come to the unit to assist, as they were the only staff member present on the unit during this time. [s. 8. (1)]

3. On another day in April 2014 at 1140hrs, staff member #100 was observed on one of the units pushing the nourishment cart. A walk through was commenced by the inspector and no other staff members were observed. It was reported by this staff member that they were the "only one on the unit as they are short staffed" and the RPN was having to work between two units due to short staffing this day shift. It was then confirmed that the morning beverages were being provided to the residents at 1150hrs on the unit despite lunch being scheduled at 1200hrs and 1300hrs respectively.
A short time later, the inspector spoke with the Acting DOC regarding staffing, the number of staff present on the unit at this present time and that nourishments were being given out at this time. The Acting DOC then reported to the inspector that the RPN was present, despite the inspector not seeing them on the unit and as had previously been confirmed with staff member #100. [s. 8. (1)]

4. An interview was conducted with a family member of one of the residents in the census sample. They stated that they had concerns about the unit having only one staff member to provide care to the residents at times during their visits to the home. They also stated that residents are left waiting for long time periods for assistance as a result of only having one person available to provide resident care for the entire floor.

During an interview with the Executive Director (ED) on April 15, 2014 regarding the home's staffing plan, it was stated that all the units are staffed the same for days and evenings, with one RPN and two PSWs, except for the third floor which has an extra PSW on the day shift. In addition, it was reported that on the night shift there are one to two RNs (currently two night shifts a week are staffed with two registered nurses but this will be decreasing in the future), one RPN for the building and one PSW on each unit with one float PSW to assist as required. It was also reported to the inspector that currently extra staff are in place to assist with the renovation moves in the home, and that restorative care aides also assist with walking of residents and some care. The ED was asked about situations where only one staff member was on a unit, they stated that the remaining one staff member could call another unit for assistance and that the home is currently reviewing break times to allow more staggering of breaks. The ED explained that most situations of units having one staff member occur during staff break times and that the only resident care that requires two staff is for lifting assistance.

Additional interviews related to unit staffing levels were conducted on April 17, 2014 with the Regional Manager of Clinical Services and the ADOC. The ADOC reported that there are to be two staff members on each unit at all times for day and evenings shifts and outlined that staff are to stagger breaks to meet this expectation. It was reported by the ADOC that the home has developed a break routine to ensure that two staff members remain on the units to provide resident care. It was then reported by the ADOC that staff do not continually follow the break routine and this has resulted in times where staff are alone on the unit to provide care to all the residents.

The home failed to ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents. [s. 8. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On April 16, 2014, the Executive Director told the inspector that they did not submit a Critical Incident System report to the Director in regards to an incident of verbal abuse towards a resident by a staff member, that had been witnessed by the home's Director of Care in June 2013.

A compliance order, specific to LTCHA 2007,S.O.2007,c.8,s.24(1) had been issued previously on June 8, 2012, inspection #2012_053122_0011.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On a day in April 2014, the medication cart on one of the units was reviewed for its contents and it was identified that a bottle of Docusate Sodium 100mg had expired in October 2013.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, iv) that complies with manufacturer's instructions for the storage of the drugs [s. 129. (1) (a)]

2. On another day in April 2014, a container of prescription labelled cream, with resident #707's name, was found in a resident room on the sink counter. Additionally, there were no residents with this name in this room. [s. 129. (1) (a) (ii)]

3. On another day in April 2014, the inspector observed the treatment cart on one of the units in the hallway, unlocked, and accessible. Within the cart were containers of prescription labelled creams for several residents. Specifically, for residents #501, #704, #705, #560, #706, and #707. The unlocked, accessible treatment cart was confirmed with staff member #103. [s. 129. (1) (a) (ii)]

4. On another day in April 2014, the treatment cart located in the corridor outside of the medication room on one of the units, was observed by the inspector to be unlocked. The drawers contained prescription treatment creams for five different residents.
On a different day in April 2014, the treatment cart located in the corridor outside of the medication room on one of the units, was observed to be unlocked. The drawers contained prescription treatment creams for five different residents. Specifically, for residents #703, #801, #702, #521 resident #476. [s. 129. (1) (a) (ii)]

5. On a day in April 2014, the treatment cart on one of the units was unlocked and the inspector was able to access multiple treatment creams inside, and no staff members were in sight of the cart.
On another day in April 2014, the treatment cart on one of the other units was unlocked and the inspector could gain access to the contents.

A Written Notification/Voluntary Plan of Correction specific to O.Reg.79/10,s.129(1)(a)(ii) was previously issued on June 11, 2012, inspection #2012_053122_0014.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. During a review of resident #701's health care record, an entry in the progress notes indicated that this resident received a glass of regular milk on a particular day in April 2014 and subsequently had adverse effects. Another progress note dated approximately one month prior, identified a similar incident. The allergy list for resident #701 listed an intolerance to certain foods/beverages and the current care plan as found online in Point Click Care also noted this intolerance. A discussion was held with the Registered Dietitian (RD) and it was determined that they were unaware that resident #701 had two recent occurrences, over an approximate six week time period, in which they were provided with regular milk not the ordered lactose free Lactaid. The dietary reference sheets in the home's kitchen, also note Lactaid to be given and that this resident has an intolerance. Dietary staff members reported that Lactaid is poured by the dietary staff into blue clear plastic glasses and then provided to the appropriate residents and then regular milk is served in clear plastic glasses by the PSW servers and served to other residents. The Food Service Manager (FSM) was interviewed and reported that they were also unaware that resident #701 received regular milk on two separate occasions, over an approximate six week time period and was unaware of the dietary process of using a different colour glasses for the Lactaid milk. Three separate areas of resident #701's health care record identified an intolerance to regular milk as did the dietary reference sheets in the home's kitchen. On two different occasions, resident #701 received regular milk despite having a documented intolerance and on one occasion, there was documentation in the progress notes identifying that the resident experienced adverse effects.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. During a walk through of one of the home's units, in April 2014, the door to gain access to the room in which the laundry chute is located, was propped open and staff were not observed in the area. This is a non-residential area.

The licensee failed to ensure that the following rules are complied with: 2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On a particular day in April 2014, the red cord from the call bell separated from the wall in a resident room when it was pulled and therefore the communication system was not able to be easily accessed by residents. [s. 17. (1) (a)]

2. On another day in April 2014, the inspector pulled the red cord on the call bell in the shared washroom in a resident room and the cord disengaged from the wall and did not activate the communication and response system. [s. 17. (1) (a)]

3. On a day in April 2014, the red cord for the call bell in one of the hallway washrooms was observed to be pulled off of the wall and therefore the communication system was not able to be easily accessed by residents. This was brought to the attention of the ED, as they were in the hallway at the time and they would notify maintenance for repair. [s. 17. (1) (a)]

4. On a particular evening in April 2014, the inspector was walking in the hall outside of resident #801's room. The inspector heard the resident call out "nurse" a couple of times. The inspector asked the resident if they required assistance and they stated that they did and that they did not have a call bell. The inspector looked around the resident's bed and noted that the call bell was tucked between the resident's side rail and air mattress and could not be accessed and used easily by the resident. The inspector assisted the resident with engaging the call bell.

The licensee failed to ensure that the resident-staff communication responses system can be easily seen, accessed, and used by residents, staff and visitors at all times. [s. 17. (1) (a)]

5. On a day in April 2014, resident #447's room call bell was checked and became stuck in the "on" position. Staff member #117 confirmed the call-bell was stuck "on" and they planned to notify the maintenance staff. [s. 17. (1) (b)]

6. On another day in April 2014, resident #421's room call bell did not ring when pushed and therefore found to be non-working. Staff member #101 confirmed that the call bell was not working and planned to notify maintenance.

The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that, (b) is on at all times; [s. 17. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times and is on at all times, to be implemented voluntarily.

WN #8: 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The Executive Director (ED) provided inspector #106 with a copy of a letter of discipline given to a staff member in regards to an incident of witnessed verbal abuse which had occurred in mid 2013. The ED told the inspector that an investigation into the incident of verbal abuse had not been conducted. The ED also confirmed that they had approved the letter prior to it being given to the employee.

The licensee failed to ensure that every alleged, suspected or witness incident that the licensee knows of, or that is reported is immediately investigated. [s. 23. (1) (a)]

2. A Critical Incident System report was submitted to the Director at the end of August 2013 with a status change a few days later. The licensee's results of their investigation were not reported to the Director.
On April 15, 2014, the inspector conducted an interview with the ED and it was reported that the licensee's investigation of the incident determined that resident #701's rights were violated yet this was not reported to the Director.

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1)(b). [s. 23. (2)]

3. A Critical Incident System report was submitted to the Director in 2013 for alleged abuse/neglect of resident #700 by a staff member. An interview was conducted with the ED and it was identified that the licensee's investigation results and action were not reported to the Director.

The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1)(b). [s. 23. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that every alleged, suspected or witness incident that the licensee knows of, or that is reported is immediately investigated and the results of every investigation undertaken under clause (1) (a), and every action taken under clause(1)(b) is reported to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. On four separate days in April 2014, the inspector, observed that Resident #801's wheelchair had a build up of ground in dirt and debris on the arm rest with the steering mechanism, sides of cushion and wheelchair and the footrest. The right arm rest was also covered in duct tape that was soiled and fraying.

The licensee failed to ensure that the residents have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required. [s. 37. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that residents have their personal items cleaned as required, specifically resident #801's wheelchair, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. On a particular day in April 2014, the inspector observed resident #801, eating lunch in bed. The RPN told the inspector that the resident was eating in bed because their wheelchair was broken. The resident informed the inspector that their wheelchair had been broken for about four days.

The inspector interviewed staff members #105 and #106 who reported they were informed that the chair was broken and was waiting to be picked up for repair.

Both staff members reported that there are no chairs available in the home for resident #801 to use until their wheelchair is repaired.

The licensee failed to ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. [s. 39.]

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 that ensures that mobility devices, including wheelchairs, are available at all times to residents who require them on a short-term basis, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The health care record for resident #432 was reviewed by the inspector in April 2014 and the weights for the months of March and April 2014 were not documented as was confirmed by the Registered Dietitian (RD). The most recent MDS quarterly review from January 2014, identified resident #432 as a high nutritional risk.

The licensee failed to ensure that the programs include, (i) weight on admission and monthly thereafter. [s. 68. (2) (e) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the nutrition care and hydration programs include, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During resident interviews in April 2014, resident #433 told inspector #534 that "sometimes soup and mashed potatoes are just lukewarm", additionally, resident #461 voiced to inspector #106 "The food is not always served at the proper temperature. It is often cold." Interviews were conducted with staff member #107 and the Food Service Manager (FSM) in April 2014. The FSM provided the Revera policy for food temperatures entitled "FSO-D-30-Nov.2011 Meal Service Temperature Standard" and the home's food temperature documentation records entitled "Cook's Meal Production Daily Temperature Records" to inspector #534. The inspector noted that the home's policy outlines that cooks and food service workers are to record the temperatures of menu items for all diet types and textures immediately after taking the temperatures. Staff member #107 and the FSM confirmed this was the home's practice for ensuring temperature standards. The policy further outlines that if temperatures are not recorded, the FSM or designate is to initial and follow-up. When the inspector reviewed the daily temperature records for the time period of January 2014 to April 2014 many temperatures were blank with no documentation and according to the FSM "only 45% of food temperatures are currently being documented". The FSM further explained that cooks are seen taking temperatures but not sure if the temperatures are always being documented.

The licensee failed to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; [s. 72. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :

1. On a day in April 2014, the ED gave a copy of Policy # LP-BC-20, "Resident Non-Abuse" and "Staff Reporting & Whistleblowing Protection", policy # LP-B-20_Appendix E ON to inspector #106. Inspector #106 reviewed the policies and found that, the home's written policy to promote zero tolerance of abuse and neglect of residents does not identify the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations.

The Licensee failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations. [s. 96. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the home's written policy to promote zero tolerance of abuse and neglect of residents identifies the training and retraining requirements for all staff, specifically regarding training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid such situations, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. A respiratory outbreak was declared in the home by the Public Health Unit in mid April 2014. A Critical Incident System report was submitted to the Director four days later in April 2014 outlining the details of the outbreak within the home. An interview was conducted with the Regional Manager of Clinical Services and it was confirmed that the Director had not been informed immediately of the outbreak.

The licensee failed to ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. [s. 107. (1) 5.]

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 that will ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4): 5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On a particular day in April 2014, during the late morning, inspector #106 observed resident #461 sitting in the common TV lounge in their wheelchair, dressed in a t-shirt that had a large soiled area on their lower abdomen, a brief and a soaker pad covering their knees.

The licensee failed to ensure that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. On one day in April 2014, inspector #196 entered one of the home's units via the stairwell across from a resident room and walked onto a piece of cut flooring material that was lying on the floor awaiting installation. Some of the edges of the flooring material were slightly elevated and was a potential trip hazard to those walking in the area. Inspector #196 discussed the flooring with staff member #116 who also noted the piece of flooring as a trip hazard to staff and to any residents. The ED was informed by the inspector at the time of the observations and the contractor was observed to roll up the piece of flooring and move it to another area.

The licensee failed to ensure that the home is a safe and secure environment for its residents. [s. 5.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. In July 2013, the licensee submitted a Critical Incident System report to the Director outlining an allegation of staff to resident abuse as brought forward by a family member. The licensee conducted an investigation and determined that a staff member had not provided nail care to resident #700, despite having documented that it was done.

The licensee failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

1. The Environmental Service Manager (ESM) told the inspector that they have a key to access the storage room that contains the government drug supply. This person is not regulated to be able to dispense, prescribe or administer drugs in the home, nor are they the Administrator.

The licensee failed to ensure that steps are taken to ensure the security of the drug supply, including the following: 2. Access to these areas shall be restricted to, i. persons who may dispense, prescribe or administer drugs in the home, and ii. the Administrator [s. 130. 2.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2013_217137_0056	106
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2013_217137_0056	106

Issued on this 5th day of June, 2014

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), KARI WEAVER (534), MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2014_246196_0006
Log No. / Registre no:	S-000130-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 29, 2014
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

Ontario

Ministry of Health and Long-Term Care

Ministére 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to resident #601 and #708 as specified in the plan.

Grounds / Motifs :

1. A Critical Incident System report was submitted to the Director in December 2013 for an incident that caused an injury for which resident #601 was taken to hospital and which resulted in a significant change in their health status.
The progress notes for resident #601 were reviewed and identified that the resident had fallen sometime during a particular night shift in December 2013 but it was not reported by the night shift staff. Staff member #115 documented that on the night shift a support staff worker had assisted the resident up to the toilet and left the resident unattended for "a minute" and it was during this time period the resident attempted to get themselves off the toilet when the injury to the resident occurred. The information that was documented by staff member #115 had been obtained from the resident. When the resident was seen and assessed by the RPN the following morning, it was noted that the resident had an injury and the RN was called to assess. In the resident care plan that was in place prior to the fall, interventions were noted that when the resident is toileted, staff are to remain with the resident to ensure the resident remains seated. According to the progress notes, the night shift support person did not stay with the resident when the resident was toileted despite the clear directions in the care plan directing staff to stay with the resident.

2. On a particular morning in April 2014, it was reported to the inspector that resident #708 had a fall out of bed. According to staff member #113, the bed alarm was not on the resident's bed as it had been removed and was waiting for a battery and therefore it hadn't activated. Management staff member #109 confirmed to the inspector that the alarm had been taken off the bed on the night shift and was awaiting a battery change. The current care plan with a focus of "high risk for falls" was reviewed and included the intervention of "bed alarm is used". On a particular day in April 2014, resident #708 did not have a bed alarm in use as was included in the plan of care.

Compliance Orders, specific to LTCHA 2007,S.O.2007,c.8,s.6(7), had previously been issued on October 15, 2012, inspection #2012_053122_0014 and also on June 5, 2013 in inspection #2013_224122_0001.

The home failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 13, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee shall ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents.

Grounds / Motifs :

1. An interview was conducted with a family member of one of the residents in the in the home. They stated that they had concerns about the unit having only one staff member to provide care to the residents at times during their visits to the home. They also stated that residents are left waiting for long time periods for assistance as a result of only having one person available to provide resident care for the entire floor.
During an interview with the Executive Director (ED) regarding the home's staffing plan, it was stated that all the units are staffed the same for days and evenings, with one RPN and two PSWs, except for the third floor which has an extra PSW on the day shift. In addition, it was reported that on the night shift there are one to two RNs (currently two night shifts a week are staffed with two registered nurses but this will be decreasing in the future), one RPN for the building and one PSW on each unit with one float PSW to assist as required. It was also reported to the inspector that currently extra staff were in place to assist with the renovation moves in the home, and that restorative care aides also assist with walking of residents and some care. The ED was asked about situations where only one staff member was on a unit, they stated that the

remaining one staff member could call another unit for assistance and that the home is currently reviewing break times to allow more staggering of breaks. The ED explained that most situations of units having one staff member occur during staff break times and that the only resident care that requires two staff is for lifting assistance.
Additional interviews related to unit staffing levels were conducted with the Regional Manager of Clinical Services and the ADOC. The ADOC reported that there are to be two staff members on each unit at all times for day and evenings shifts and outlined that staff are to stagger breaks to meet this expectation. It was reported by the ADOC that the home has developed a break routine to ensure that two staff members remain on the units to provide resident care. It was then reported by the ADOC that staff do not continually follow the break routine and this has resulted in times where staff are alone on the unit to provide care to all the residents.

(534)

2. On a particular day in April 2014, the inspector spoke with staff member #101 and it was determined that they were the only staff on that particular unit to provide care for approximately 25 residents. The other PSW was in the main floor dining room assisting with meal service from 1230hrs through to 1400hrs and the RPN had been called to attend to another unit.
On another day in April 2014 in the early evening, a visiting family member sitting in the common area of one of the units, mentioned to the inspector that they had not seen any staff in the previous twenty minutes. The family member's relative was not in any need of assistance, they were just was concerned that no staff were around. Inspector #196 did a walk through of the unit and spoke with staff member #102 who confirmed that they were the only staff member on the unit because of the other staff members assisting with dining service on the main floor and having their meal breaks. A short time later, resident #704 was observed lying on their back, on the floor in their room with staff member #102 present. According to this staff member, the resident had fallen out of the bed and that the RN has been called to come to the unit to assist, as they were the only staff member present on the unit during this time.
On another day in April 2014 at 1140hrs, staff member #100 was observed on one of the units pushing the nourishment cart. A walk through was commenced by the inspector and no other staff members were observed. It was reported by this staff member that they were the "only one on the unit as they are short

staffed" and the RPN was having to work between two units due to short staffing this day shift. It was then confirmed that the morning beverages were being provided to the residents at 1150hrs on the unit despite lunch being scheduled at 1200hrs and 1300hrs respectively.
A short time later, the inspector spoke with the Acting DOC regarding staffing, the number of staff working on the unit at this present time and that nourishments were being given out at this time. The Acting DOC then reported to the inspector that the RPN was present, despite the inspector not seeing them on the unit and as had been previously confirmed with staff member #100.

The home failed to ensure that there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 11, 2014

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Grounds / Motifs :

1. On April 16, 2014, the Executive Director told the inspector that they did not submit a Critical Incident System report to the Director in regards to an incident of verbal abuse to a resident by a staff member that had been witnessed by the home's Director of Care in June 2013.

A Compliance Order, specific to LTCHA 2007,S.O.2007,c.8,s.24(1) had been issued previously on June 8, 2012, inspection #2012_053122_0011.

The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. (106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 13, 2014

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

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked.

Grounds / Motifs :

1. On a day in April 2014, the treatment cart on one of the units was unlocked and the inspector was able to access to multiple treatment creams inside, and no staff members were in sight of the cart.
On another day in April 2014, the treatment cart on one of the other units was unlocked and the inspector could gain access to the contents.
(196)

2. On another day in April 2014, the treatment cart located in the corridor outside of the medication room on one of the units, was observed to be unlocked. The drawers contained prescription treatment creams for five different residents.
On a different day in April 2014, the treatment cart located in the corridor outside of the medication room on one of the units, was observed to be unlocked. The drawers contained prescription treatment creams for five different residents. Specifically, creams for resident #703, #801, #702, #521 and #476. (196)

3. On another day in April 2014, the treatment cart on one of the units in the hallway was unlocked and accessible. Within the cart were containers of prescription labelled creams for resident #501, #704, #705, #560, #706, and #707. The unlocked, accessible treatment cart was confirmed with staff member #103. (534)

4. On a day in April 2014, a container of prescription labelled cream, with resident #707's name, was found in a resident room on the sink counter. Additionally, there were no residents with this name in this room.

A Written Notification/Voluntary Plan of Correction specific to O.Reg.79/10,s.129(1)(a)(ii) was previously issued on June 11, 2012, inspection #2012_053122_0014.

The licensee failed to ensure that (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. (196)

This order must be complied with by /
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Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

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

Order / Ordre :

The licensee shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of resident #701's diets, special needs and preferences.

Grounds / Motifs :

1. During a review of resident #701's health care record, an entry in the progress notes indicated that this resident received a glass of regular milk on a particular day in April 2014 and subsequently had adverse effects. Another progress note dated approximately one month prior, identified a similar incident. The allergy list for resident #701 listed an intolerance to certain foods/beverages and the current care plan as found online in Point Click Care also noted this intolerance. A discussion was held with the Registered Dietitian (RD) and it was determined that they were unaware that resident #701 had two recent occurrences, over an approximate six week time period, in which they were provided with regular milk not the ordered lactose free Lactaid. The dietary reference sheets in the home's kitchen, also note Lactaid to be given and that this resident has an intolerance. Dietary staff members reported that Lactaid is poured by the dietary staff into blue clear plastic glasses and then provided to the appropriate residents and then regular milk is served in clear plastic glasses by the PSW servers and served to other residents. The Food Service Manager (FSM) was interviewed and reported that they were also unaware that resident #701 received regular milk on two separate occasions, over an approximate six week time period and was unaware of the dietary process of using a different colour glasses for the Lactaid milk.
Three separate areas of resident #701's health care record identified an intolerance to regular milk as did the dietary reference sheets in the home's kitchen. On two different occasions, resident #701 received regular milk despite having a documented intolerance and on one occasion, there was in the progress notes identifying that the resident experienced adverse effects.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. (196)

This order must be complied with by /
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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.

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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 29th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lauren Tenhunen

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