**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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

**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

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

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

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

## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 9, 2015 | 2015_235507_0012 | T-1708-15 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

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

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

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON  M4E 2V6

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

STELLA NG (507), ARIEL JONES (566), TIINA TRALMAN (162)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): May 25, 26, 28, 29, June 1, 2 and 3, 2015.**

**The following Complaint Intake was inspected concurrently with this Resident Quality Inspection: T- 1195-14.**
**The following Critical Incident Intake was inspected concurrently with this Resident Quality Inspection: T- 1904-15.**

**During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), associate director of care (ADOC), staff educator (SE), registered dietitian (RD), dietary manager (DM), dietary aide (DA), registered nursing staff, personal support workers (PSWs), minimum data set/ resident assessment instrument (MDS/RAI) coordinator, physiotherapist, residents, substitute decision makers (SDMs) and family members of residents.**

**The inspectors conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining and snack services, record review of resident and home records, meeting minutes for Residents’ Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**

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

**7 WN(s)**
**0 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

---

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**
**2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).**
**3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).**
**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).**
**5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).**
**6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).**
**7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**
**9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).**
**10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal**

**Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**
**12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).**
**13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).**
**14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).**
**15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).**
**16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).**
**17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,**
**i. the Residents' Council,**
**ii. the Family Council,**
**iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,**
**iv. staff members,**
**v. government officials,**
**vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).**
**18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).**
**19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).**
**20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).**
**21. Every resident has the right to meet privately with his or her spouse or another**

**person in a room that assures privacy. 2007, c. 8, s. 3 (1).**
**22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).**
**23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).**
**24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).**
**25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).**
**26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).**
**27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident’s right to be cared for in a manner consistent with his or her needs is fully respected and promoted.

Record review of an identified resident’s written plan of care revealed that the resident requires a mobility aide for ambulation and one person assistance for transfer. Record review of the home’s investigation notes revealed that on an identified date, the identified resident requested an identified PSW to assist him/her to bed. The PSW told the resident that he/she was taking the laundry down to the basement and that he/she would be back in a few minutes to assist the resident to bed. The resident went to the nursing station and requested an identified registered staff to assist him/her to bed, which was done immediately.

The home conducted an internal investigation on the above mentioned incident and determined that the identified PSW failed to prioritize the resident’s care needs upon request to be transferred to bed.

Interview with the identified PSW confirmed that he/she did not respond to the resident’s request to be assisted to bed upon request. The PSW acknowledged that he/she should have assisted the resident to bed upon request.

Interviews with the ADOC and DOC confirmed that the resident’s right to be cared for in a manner consistent with his/her needs was not respected and promoted. [s. 3. (1)]

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (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 licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

An interview with an identified resident revealed that he/she has own dentures but never wears them due to improper fit, and that he/she is not interested in seeing a denturist. The resident reported that he/she can perform his/her own mouth care when provided with the appropriate supplies.

Interviews with two identified PSWs revealed inconsistencies regarding the resident’s oral care needs.

A record review of the resident’s written plan of care failed to reveal documentation specific to the resident’s oral care/hygiene needs. Review of the resident’s kardex on Point of Care (POC) revealed that the resident requires physical assistance of one staff for bathing, personal hygiene, and oral care, but the details of the resident's oral care needs are not outlined.

An interview with an identified registered staff confirmed that the resident can perform his/her own mouth care with appropriate set up assistance, that he/she has own dentures but prefers not to wear them, and that the written plan of care does not include documentation specific to the resident's oral care and hygiene needs. An interview with the DOC confirmed that the resident’s written plan of care does not set out clear directions to staff and others who provide direct care to the resident related to the oral

care needs of the resident. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff who provide direct care to a resident are kept aware of the contents of the resident’s plan of care.

Review of an identified resident’s Minimum Data Set (MDS) assessment on an identified date revealed that the resident’s vision is impaired, and he/she does not use any visual aids. Review of the resident’s written plan of care dated 14 days after the completion of the above mentioned MDS assessment indicated that interventions for the resident's impaired vision include:
• staff to report any acute eye changes to Nurse,
• requires explanation of procedures before starting,
• chooses not to wear eyeglasses,
• wears sunglasses for outdoors, and
• call bell and light pull cords within easy reach and in a consistent location.

During the course of inspection, the inspector observed the resident did not wear glasses.

An interview with the identified resident's assigned PSW revealed that the identified PSW was not aware of any of the above interventions for the resident’s impaired vision. Interview with an identified ADOC confirmed that the home’s expectation is for all staff to be aware of the care plan of their assigned residents. The ADOC further stated that the identified PSW was not aware of the resident's interventions for his/her impaired vision and this was not acceptable. [s. 6. (8)]

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

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

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the plan of care for the resident was based on an interdisciplinary assessment of the resident's vision.

Record review of the MDS assessment on an identified date indicated that an identified resident has highly impaired vision, decreased peripheral vision, and does not use visual appliances or corrective lenses. The Resident Assessment Protocol (RAP) summary indicated that care planning would be done to minimize risks and avoid complications. Record review of the written plan of care revealed that interventions for the resident's assessed impaired vision was not reflected in the written plan of care

During the course of the inspection, the inspector observed the resident did not wear glasses.

Interviews with registered staff and the DOC confirmed that if the vision RAP was triggered for the resident, then the problem and its interventions should be outlined on the resident's plan of care. [s. 26. (3) 4.]

2. The licensee has failed to ensure that the plan of care for the resident was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Record review of the MDS assessment on an identified date indicated that an identified resident is bedfast all or most of the time, and that he/she is awake in the morning, afternoon and evening. The resident’s progress notes indicated he/she was ill around the time of the MDS assessment seven day observation period and was spending more time in bed. A review of the resident’s written plan of care and kardex failed to reveal a section related to the resident’s sleep patterns and preferences.

Observations, resident and staff interviews revealed that the resident is up all day in his/her wheelchair, and able to self-propel independently both on and off the unit. The resident reported that he/she had been sick a couple of months ago and spending more time in bed, and staff interviews confirmed that the resident is not currently bedfast.

The DOC confirmed that the resident’s sleep patterns and preferences should be outlined on his/her written plan of care. [s. 26. (3) 21.]

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of residents with responsive behaviours.

Record review for an identified resident indicated that the resident is at high nutritional risk as evidenced by requiring therapeutic diet and a decline in cognitive functioning as evidenced by not cooperating during meal services.

Interviews with identified PSWs and an identified registered staff revealed that the resident continues to create interruptions during meal services. Furthermore, staff indicate they monitor the resident during the meal services and implement identified strategies to minimize this behaviour.

Interview with the identified registered staff confirmed that written strategies for the resident’s responsive behaviours have not been developed as required. [s. 53. (1)]

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,**
**(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff comply with the home's policies and procedures for safe operation related to the dining service.

A review of the home's policy entitled Meal Service Temperature Standard (#FSO-D-30, revised November 2011), indicates that staff are required to take and record the temperatures of all menu items.

Observation conducted on an identified date during the lunch meal service on an identified floor dining room revealed that an identified dietary staff member did not take food temperatures for all menu items. At the end of the meal service, the inspector reviewed the food temperature documentation and identified the temperature of a number of food items were not taken.

Interview with the identified DA confirmed that he/she did not take the temperature of all the planned menu items. Interview with the DM confirmed that the DA should measure the food temperature for all menu items. [s. 72. (7) (a)]

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On an identified date, the inspector observed an identified treatment cart on an identified floor to be unlocked. The cart was stored in an alcove near the south tub room, across from residents' rooms. The cart was noted to obtain various prescription creams and ointments.

An interview with an identified registered staff revealed that the treatment cart does not lock.

On another two identified dates, the inspector observed an identified treatment cart on another identified floor to be unlocked, and stored in a similar area as the cart on the first identified floor. The treatment cart contained multiple prescribed creams and ointments.

An interview with an identified registered staff confirmed that the cart contained prescription creams, and that it should be locked when not in use.

An interview with the DOC confirmed that if the treatment carts are left unlocked, then the drugs are not safely stored. [s. 129. (1) (a) (ii)]

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**Findings/Faits saillants :**

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

A review of the home's policy entitled Routine Practices (#IPC-B-10, revised December 2014) indicates that staff should perform hand hygiene before leaving the resident's environment and touching clean surfaces.

On an identified date, the inspector observed an identified PSW coming out of an identified resident's room, and the PSW was holding a garbage bag with gloves on. The identified PSW then took the key from the wall and opened the shower room with his/her gloved left hand.

An interview with the identified PSW confirmed that he/she did not take off the gloves after changing the resident. An interview with an identified registered staff confirmed that hand hygiene should be performed after providing care, and gloves should be taken off prior to leaving the resident's room. [s. 229. (4)]

2. A review of the home's policy entitled Routine Practices (#IPC-B-10, revised December 2014), indicates that staff should perform hand hygiene before, between and after activities that may result in cross-contamination.

On an identified date, during the lunch meal service on an identified floor, the inspector observed an identified staff member remove soiled dishes from the dining table, scrape the plates and place them into a bin. The staff member returned to the dining table to resume assisting an identified resident with eating and drinking without performing hand hygiene.

An interview with the staff member confirmed he/she did not perform hand hygiene after handling soiled dishes. An interview with an identified registered staff confirmed that the home's policy requires staff to wash hands or use the sanitizer between removing dishes to the soiled area and returning to assisting residents. [s. 229. (4)]

---

**Issued on this 30th day of June, 2015**

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

**Original report signed by the inspector.**