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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 29, 2016	2016_340566_0013	019795-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

MAIN STREET TERRACE
77 MAIN STREET TORONTO ON M4E 2V6

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

ARIEL JONES (566), JUDITH HART (513), SARAH KENNEDY (605), SUSAN SEMEREDY (501), VERON ASH (535)

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): July 5, 6, 7, 11, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, and August 2, 2016.

The following critical incident (CI) inspections were conducted concurrently with the RQI: 019296-16 (related to abuse), 021115-16 (related to abuse), 021927-16 (related to abuse), 007614-14 (related to abuse, responsive behaviours and hospitalization), 008189-14 (related to abuse and responsive behaviours), 035105-

15 (related to abuse and responsive behaviours), 001647-15 (related to abuse and responsive behaviours), 002517-15 (related to abuse and responsive behaviours), 031207-15 (related to abuse and responsive behaviours) , 011037-15 (related to abuse, responsive behaviours and hospitalization), 006952-15 (related to abuse, trust accounts and Residents' Council), 012389-15 (related to maintenance and falls), 015015-15 (related to falls and personal support services), 020199-16 (related to plan of care), 001900-14 (related to abuse), 012020-16 (related to abuse and responsive behaviours) and 009291-15 (related to reporting and complaints).

The following complaint inspections were conducted concurrently with the RQI: 007187-14 (related to personal support services), 009682-14 (related to hospitalization), 004960-14 (related to abuse) and 007362-14 (related to abuse and responsive behaviours).

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), assistant DOC (ADOC), staff educator, registered dietitian (RD), physiotherapist (PT), programs manager, environmental services manager (ESM), dietary manager, registered nursing staff, personal support workers (PSWs), dietary aide, housekeepers, receptionist, residents, substitute decision makers (SDMs), Residents' Council representative and Family Council president.

During the course of the inspection, the inspector(s): conducted a tour of the home; observed meal service, medication administration, staff to resident interactions and the provision of care, resident to resident interactions; and reviewed resident health care records, staff training records, meeting minutes for Residents' Council and Family Council, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

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

For the purposes of the definition of "neglect" in section 5 of the Regulations, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted six (6) critical incident reports (CIR) related to the elopement of resident #045 between an identified date in July 2014 and an identified date in September 2015.
A review of the resident's resident assessment instrument-minimum data set (RAI-MDS) assessment from an identified date in May 2014, revealed resident #045 was assessed as moderately impaired with poor decision making skills requiring cues or supervision; and on an identified date in March 2014, the resident's electronic care plan was updated, alerting staff that the resident was at high risk for elopement.

The first documented episode of elopement was on an identified date in July 2014. As per the CIR, the resident was not in bed and could not be located in the facility at an identified time during shift change. Approximately five hours later the resident was returned to the facility accompanied by the police. The resident stated that he/she had walked to a specific location downtown.

During an interview with registered staff #106, he/she stated that the resident left the home through the front door either when a visitor left the building or when another resident that had consent and access to the code for the door went outside. During an interview with the home's assistant director of care (ADOC) #102, he/she stated that after the resident's return, they tried performing an assessment, and then tried to transfer the resident to hospital for examination and treatment, however the resident refused both options. The resident was placed on one-to-one (1:1) monitoring for 72 hours, then on 30 minute checks going forward.

Record review showed that on a second identified date in July 2014, the resident left his/her unit, as care planned, to attend a meal in the first floor dining room. At an identified time during the meal service the resident was reported missing from the dining room by staff. The staff searched the home and immediate surrounding areas and the resident was located at a nearby intersection. Upon return to the home, the resident was again placed on 1:1 monitoring for 72 hours, then on 30 minute checks going forward.

The resident's third episode of elopement occurred on an identified date in August 2014.

An interview with registered staff #106 revealed on this date in August 2014, the resident was permitted to leave the facility unescorted and unsupervised. During interviews with the director of care (DOC) #101 and the ADOC #102, they both stated that they saw resident #045 walking away from the home; and that approximately two hours later, the resident returned to the home independently. Record review showed that the resident’s SDM was upset by this incident of elopement and stated that the facility needs to keep a closer eye on the resident. During an interview with the home’s ADOC #102, he/she stated that after the above conversation with the SDM, the physician was called and the decision was made to transfer the resident to an acute care facility for assessment. The resident was transferred to hospital and returned to the home with an identified diagnosis, a new prescription for an identified medication for the diagnosis, and a referral to a specialized resource. Following this episode, the resident was placed on 1:1 continuous monitoring.

An interview was conducted with the home’s DOC #101, during which he/she stated that alternate interventions or strategies should have been implemented when the 30 minute checks were ineffective in order to prevent the recurrence of resident #045’s elopements from the facility. This pattern of inaction to develop and implement further strategies to prevent recurrence of the resident's elopement jeopardized the health, safety and well-being of resident #045. [s. 19. (1)]

2. For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A review of an identified CIR revealed that on an identified date in April 2014, during a meal service, resident #052 was hit on an identified part of the body by resident #053. During an interview with RPN #150, he/she stated that resident #053 has a history of unprovoked aggression towards staff and other residents. RPN #150 confirmed that the incident in the dining room was unprovoked and resulted in slight redness to the resident's body part, and that resident #053 was transferred to hospital for assessment.

A review of an identified CIR revealed that on an identified date in November 2015, there was a physical altercation between residents #052 and #053 during a meal service. During an interview with resident #052, he/she stated he/she reached for a container on the table and co-resident #053, who was seated at the same dining room table, proceeded to take the container away and punch him/her on part of the body causing identified injuries to that area. An interview with the ADOC confirmed that the incident

occurred in the dining room during the meal service and that both residents were separated following the incident to prevent further altercation.

Interview with the DOC confirmed that these unprovoked incidents constituted abuse of resident #052 by co-resident #053. [s. 19. (1)]

3. A review of an identified CIR and progress notes from an identified date in May 2015, indicated resident #026 jumped on resident #027 from behind and began to punch, kick and scratch the resident. The incident was not witnessed in its entirety and it is unclear as to whether resident #026 was provoked or not. Resident #027 sustained multiple injuries to various parts of the body. Resident #027 was transferred to hospital for treatment and subsequently returned to the home.

A review of the RAI-MDS assessments for both residents #026 and #027 indicated that they had a medical diagnosis of an identified form of dementia. A review of resident #026's progress notes revealed there was no history of aggressive behaviours toward other residents in the past. The subsequent written plan of care from a second identified date in May 2015 identified strategies to reduce resident contact.

Interviews with registered staff #104 and the DOC confirmed that on the identified occasion resident #027 was not protected from abuse by resident #026. [s. 19. (1)]

4. A review of an identified CIR revealed that resident #048 experiences identified sensory deficits. On an identified date in March 2014, resident #048 was sitting in his/her wheelchair in the lounge on the unit when resident #051 pushed a nearby lounge chair which made a loud noise. The loud noise and abrupt movement of the chair caused resident #048 to start screaming. An interview with PSW #146 revealed that he/she witnessed resident #051 stand up and punch resident #048 twice on an identified area of the body, causing the resident to fall out of his/her wheelchair and onto the floor. PSW #146 reportedly intervened and separated the residents to prevent further altercation. An interview with RPN #150 confirmed that resident #048 sustained identified injuries; and that resident #051 was transferred to hospital for assessment and treatment.

A review of an identified CIR revealed that on an identified date in December 2015, resident #048 and resident #047 had an altercation in their shared room. Interviews with registered staff #106 and PSW #151 confirmed that resident #047 punched resident #048 causing an identified injury; and that resident #048 was transferred to hospital for further assessment and treatment. Registered staff #106 also stated that resident #047

was transferred to hospital for assessment. An interview with the DOC revealed that resident #047 agreed to a room change upon return from hospital, and there have been no further altercations between these residents since.

An interview with the DOC confirmed that resident #048 was not protected from physical abuse by residents #051 and #047.

The home failed to protect residents #045, #052, #027, and #048 from abuse and/or neglect by anyone.

The scope of this non-compliance is isolated as it relates to four residents. The severity is actual harm/risk. The home's Compliance History Report reveals a voluntary plan of correction (VPC) was issued on April 11, 2014. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to 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.

Interviews with resident #005 on two identified dates in July 2016, revealed that there had been a recent incident involving a nurse that was reportedly rude to the resident when he/she refused his/her medication on an identified shift, and that the nurse tried to force him/her to take his/her medication. The resident reported that he/she refused the medication and spit it out when it was given to him/her. Resident interviews and observations confirmed that there was no long-term negative impact to the resident.

A record review of the home's investigation notes revealed that an incident occurred involving resident #005 and RN #108 on an identified date in June 2016, when the resident refused his/her medication, including a specific medication, on two attempts made by the RN during an identified time period. The RN then crushed all of the resident's medications in apple sauce, and returned in an attempt to administer the medications a third time. The resident again refused, however, the staff member

reportedly put the spoon containing all of the medications in the resident's mouth. The resident then reportedly spit out a portion of the medication.

A review of resident #005's June 2016 electronic medication administration record (eMAR) revealed the resident's medications were all signed off as having been administered on the identified date and shift in June 2016.

An interview with RN #108 revealed that when the resident refused the medication, the staff member reapproached the resident twice and provided education on the importance of a specific medication. He/She confirmed that he/she then crushed all of the resident's evening medication and administered them together in apple sauce. He/She stated that the resident verbally refused his/her medication, but opened his/her mouth when the spoon was provided which was interpreted as consent by the RN. The resident then spit out approximately one-third of the medication. RN #108 denied having been rude to or having yelled at the resident.

An interview with the DOC revealed that the home's policy when a resident refuses medication is to reapproach the resident and then document the medication refusal if the resident continues to refuse. The DOC and ED confirmed that residents have the right to refuse medications. The DOC confirmed that, in this incident, the resident's right to refuse medication was not respected by RN #108. [s. 3. (1) 11. ii.]

WN #3: 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the provision of the care set out in the plan of care is documented.

Record review for resident #004, including a RAI-MDS assessment from an identified date in May 2016, and progress notes revealed that the resident was living with altered skin integrity, and required extensive assistance with bed mobility.

A review of the written care plan for resident #004 from a second identified date in May 2016, indicated the resident was to be turned every two hours. The time the resident is turned was to be documented.

The turning record located in the electronic resident record system indicated that the record could not be provided for a specific period during the months of June and July 2016.

An interview with RPN #104 revealed that the turning schedule for resident #004 was discontinued in error during this specific time period between identified dates in June and July, 2016. An interview with the DOC confirmed the turning schedule was discontinued, however, the treatment continued to be provided and the provision of care set out in the plan of care was not documented. [s. 6. (9) 1.]

WN #4: 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. The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm immediately report the suspicion and the information upon which it was based to the Director.

a.) A review of an identified CIR revealed residents #028 and #029 were in the dining room when an altercation occurred, whereby resident #028 picked up an identified object from the table and threw it at resident #029. The CIR revealed the incident occurred on an identified date and time in November 2014, and was submitted to the Director on a second identified date and time in November 2014, over 24 hours later.

An interview with the ADOC and DOC confirmed the Director had not been notified by management staff prior to the second identified date in November 2014, therefore not immediately reporting the suspected abuse of resident #029 by resident #028.

b.) A review of an identified CIR revealed residents #026 and #027, who reside on an identified unit were observed lying on the floor, with resident #026 kicking, hitting and punching resident #027. Resident #027 sustained multiple injuries to various parts of the body. A review of the CIR revealed the incident occurred on an identified date and time in May 2015, and was submitted to the Director on a second identified date and time in May 2015, over 24 hours later.

An interview with the DOC confirmed the Director had not been notified by management staff prior to the second identified date in May 2015, therefore not immediately reporting the suspected abuse of resident #027 by resident #026. [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #011 was observed to have two areas of altered skin integrity on an identified upper extremity.

A review of the assessments, daily skin care record, plan of care, medication and treatment records, and progress notes for a specific period during May to July 2016, did not identify these areas of altered skin integrity.

Interview with the resident revealed the two areas of altered skin integrity on the identified upper extremity were present for an undetermined length of time.

An interview with PSW #127 revealed no alteration in skin integrity for resident #011 was observed. An interview with RN #106 confirmed that the areas of altered skin integrity were observed and that a clinically appropriate skin assessment specifically designed for skin and wound assessment was not completed. An interview with the DOC confirmed any alteration in skin integrity was to be assessed with a clinically appropriate skin assessment instrument. [s. 50. (2) (b) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that behavioural triggers have been identified for the resident demonstrating responsive behaviours, where possible.

Record review revealed that resident #049 was not capable of leaving the facility independently. A review of an identified CIR indicated that on an identified date in April 2014, resident #049 gave his/her debit card and personal identification number (PIN) to resident #050 to make an identified purchase on his/her behalf.
Resident #049 then reported to the receptionist and DOC that approximately $100 was withdrawn from his/her account. Resident #049 recalled the incident during an interview, but refused to discuss the incident further.

Staff interviews with registered and non-registered staff revealed that unit staff were unaware of the resident's tendency to give his/her debit card and PIN to co-residents to make identified purchases on his/her behalf, and that there are no triggers, strategies or interventions identified in the resident's plan of care to address this behaviour.

An interview with the DOC confirmed that the resident does give his/her debit card and PIN to other residents residing in the home to make identified purchases on his/her behalf, and that this behaviour and its triggers were not identified and assessed with strategies developed and implemented to respond to the behavior. [s. 53. (4) (a)]

2. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviors, where possible.

Staff interviews revealed that resident #053 has an identified behavior. A review of the associated CIR revealed that on an identified date in November 2015, resident #053 had a physical altercation with resident #052 in the dining room related to this behaviour, which resulted in an identified injury to resident #052.

A review of resident #053's written care plan revealed this identified behaviour and strategies to respond to this behavior were not identified or outlined. Interviews with the DOC and ADOC confirmed that this was an identified behavior for resident #053, and that strategies had not been developed and implemented to respond to this behaviour. [s. 53. (4) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

An observation on July 7, 2016, by inspector #501, revealed the presence of an identified offensive odour in an identified resident room and in the hallway outside the identified room. An observation on July 13, 2016, by inspector #605, revealed the offensive odour remained. An interview with PSW #110 confirmed there was an identified odour in the room which was also apparent in the hallway.

An interview with resident #039 who resides in the vicinity of the identified room, revealed there is always an odour in the hallway and he/she finds the smell disgusting.

An interview with housekeeper #144 revealed he/she is aware of the identified smell and spends extra time cleaning the identified room. Housekeeper #144 cleans the room in the morning and whenever PSW staff notify him/her that the room requires extra cleaning throughout the day. Staff #144 disinfects the floor, mattresses and uses a spray (metri spray) to minimize odours.

An interview with the environmental services manager (ESM) revealed the home has interventions in place to minimize offensive odours. The housekeeper cleans regularly and there is a carbolizer for odour control in the room. The procedures implemented do not sufficiently address the incidents of lingering offensive odours. [s. 87. (2) (d)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that if not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

A review of an identified CIR revealed that the report was submitted to the Director on an identified date in March 2014. An amendment to the CI was requested by the Director and sent to the licensee two days later. The amended information was received by the Director on an identified date in January 2015.

A review of an identified CIR revealed that the report was submitted to the Director on an identified date in April 2014. An amendment to the CI was requested by the Director and sent to the licensee four days later and again on an identified date in January 2015. The amended information was received by the Director on a second identified date in January 2015.

A review of an identified CIR revealed that the report was submitted to the Director on an identified date in April 2015. An amendment to the CI was requested by the Director and sent to the licensee on the same date. As of August 4, 2016, the amendment had not been submitted by the home via the critical incident system (CIS) portal.

A review of an identified CIR revealed that the report was submitted to the Director on an identified date in December 2015. An amendment to the CI was requested by the Director and sent to the licensee on the same date. As of August 4, 2016, the amendment had not been submitted by the home via the CIS portal. [s. 104. (3)]

2. A review of an identified CIR revealed that the report was submitted to the Director on an identified date in November 2014. An amendment to the CI was requested by the Director and sent to the licensee three days later. As of August 4, 2016, the amendment had not been submitted by the home via the CIS portal. [s. 104. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Record review of resident #005's eMAR revealed that he/she has multiple identified medical diagnoses that require several identified medications. The resident was known to be able to receive medications in tablet form.

A review of resident #005's physician prescriptions for medications revealed the resident was to receive three medications including an identified medication, one tablet by mouth at bedtime, which was identified as "do not crush."

A review of the June 2016 eMAR revealed on an identified date in June 2016, the eMAR was signed off by RN #108, indicating the medications scheduled for a specific administration time, including the identified medication, had been administered.

An interview with RN #108 confirmed the medications prescribed to be administered on the identified date and time in June 2016 were offered twice to resident #005 and were refused. The RN then crushed all medications prescribed for the identified date and time, including the identified medication which was not to be crushed.

An interview with the DOC confirmed the identified medication had been crushed and administered to resident #005, failing to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 18th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ARIEL JONES (566), JUDITH HART (513), SARAH KENNEDY (605), SUSAN SEMEREDY (501), VERON ASH (535)
Inspection No. / No de l'inspection :	2016_340566_0013
Log No. / Registre no:	019795-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 29, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	MAIN STREET TERRACE 77 MAIN STREET, TORONTO, ON, M4E-2V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bradshaw

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents are protected from abuse and neglect by anyone. The plan shall include the development and implementation of a system of ongoing monitoring to:
1) ensure that the behavioural triggers for residents with responsive behaviours are identified, and applicable strategies and interventions are developed and implemented in the written care plan in order to prevent resident to resident abuse, and staff to resident neglect, and
2) ensure staff are complying with the home's policy and procedures related to zero tolerance of abuse and neglect in order to protect residents from being abused by other residents in the home, and to prevent residents from being neglected by staff.

This plan is to be submitted via email to inspector ariel.jones@ontario.ca by October 31, 2016.

Grounds / Motifs :

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

For the purposes of the definition of "neglect" in section 5 of the Regulations, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home submitted six (6) critical incident reports (CIR) related to the elopement of resident #045 between an identified date in July 2014 and an identified date in September 2015.
A review of the resident's resident assessment instrument-minimum data set (RAI-MDS) assessment from an identified date in May 2014, revealed resident #045 was assessed as moderately impaired with poor decision making skills requiring cues or supervision; and on an identified date in March 2014, the resident's electronic care plan was updated, alerting staff that the resident was at high risk for elopement.

The first documented episode of elopement was on an identified date in July 2014. As per the CIR, the resident was not in bed and could not be located in the facility at an identified time during shift change. Approximately five hours later the resident was returned to the facility accompanied by the police. The resident stated that he/she had walked to a specific location downtown.

During an interview with registered staff #106, he/she stated that the resident left the home through the front door either when a visitor left the building or when another resident that had consent and access to the code for the door went outside. During an interview with the home's assistant director of care (ADOC) #102, he/she stated that after the resident's return, they tried performing an assessment, and then tried to transfer the resident to hospital for examination and treatment, however the resident refused both options. The resident was placed on one-to-one (1:1) monitoring for 72 hours, then on 30 minute checks going forward.

Record review showed that on a second identified date in July 2014, the resident left his/her unit, as care planned, to attend a meal in the first floor dining room. At an identified time during the meal service the resident was reported missing from the dining room by staff. The staff searched the home and immediate surrounding areas and the resident was located at a nearby intersection. Upon return to the home, the resident was again placed on 1:1 monitoring for 72 hours, then on 30 minute checks going forward.

The resident's third episode of elopement occurred on an identified date in August 2014. An interview with registered staff #106 revealed on this date in August 2014, the resident was permitted to leave the facility unescorted and unsupervised. During interviews with the director of care (DOC) #101 and the ADOC #102, they both stated that they saw resident #045 walking away from

the home; and that approximately two hours later, the resident returned to the home independently. Record review showed that the resident's SDM was upset by this incident of elopement and stated that the facility needs to keep a closer eye on the resident. During an interview with the home's ADOC #102, he/she stated that after the above conversation with the SDM, the physician was called and the decision was made to transfer the resident to an acute care facility for assessment. The resident was transferred to hospital and returned to the home with an identified diagnosis, a new prescription for an identified medication for the diagnosis, and a referral to a specialized resource. Following this episode, the resident was placed on 1:1 continuous monitoring.

An interview was conducted with the home's DOC #101, during which he/she stated that alternate interventions or strategies should have been implemented when the 30 minute checks were ineffective in order to prevent the recurrence of resident #045's elopements from the facility. This pattern of inaction to develop and implement further strategies to prevent recurrence of the resident's elopement jeopardized the health, safety and well-being of resident #045.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means the use of physical force by a resident that causes physical injury to another resident.

A review of an identified CIR revealed that on an identified date in April 2014, during a meal service, resident #052 was hit on an identified part of the body by resident #053. During an interview with RPN #150, he/she stated that resident #053 has a history of unprovoked aggression towards staff and other residents. RPN #150 confirmed that the incident in the dining room was unprovoked and resulted in slight redness to the resident's body part, and that resident #053 was transferred to hospital for assessment.

A review of an identified CIR revealed that on an identified date in November 2015, there was a physical altercation between residents #052 and #053 during a meal service. During an interview with resident #052, he/she stated he/she reached for a container on the table and co-resident #053, who was seated at the same dining room table, proceeded to take the container away and punch him/her on part of the body causing identified injuries to that area. An interview with the ADOC confirmed that the incident occurred in the dining room during the meal service and that both residents were separated following the incident to

prevent further altercation.

Interview with the DOC confirmed that these unprovoked incidents constituted abuse of resident #052 by co-resident #053.

A review of an identified CIR revealed that resident #048 experiences identified sensory deficits. On an identified date in March 2014, resident #048 was sitting in his/her wheelchair in the lounge on the unit when resident #051 pushed a nearby lounge chair which made a loud noise. The loud noise and abrupt movement of the chair caused resident #048 to start screaming. An interview with PSW #146 revealed that he/she witnessed resident #051 stand up and punch resident #048 twice on an identified area of the body, causing the resident to fall out of his/her wheelchair and onto the floor. PSW #146 reportedly intervened and separated the residents to prevent further altercation. An interview with RPN #150 confirmed that resident #048 sustained identified injuries; and that resident #051 was transferred to hospital for assessment and treatment.

A review of an identified CIR revealed that on an identified date in December 2015, resident #048 and resident #047 had an altercation in their shared room. Interviews with registered staff #106 and PSW #151 confirmed that resident #047 punched resident #048 causing an identified injury; and that resident #048 was transferred to hospital for further assessment and treatment. Registered staff #106 also stated that resident #047 was transferred to hospital for assessment. An interview with the DOC revealed that resident #047 agreed to a room change upon return from hospital, and there have been no further altercations between these residents since.

An interview with the DOC confirmed that resident #048 was not protected from physical abuse by residents #051 and #047. (535)

2. A review of an identified CIR and progress notes from an identified date in May 2015, indicated resident #026 jumped on resident #027 from behind and began to punch, kick and scratch the resident. The incident was not witnessed in its entirety and it is unclear as to whether resident #026 was provoked or not. Resident #027 sustained multiple injuries to various parts of the body. Resident #027 was transferred to hospital for treatment and subsequently returned to the home.

A review of the RAI-MDS assessments for both residents #026 and #027 indicated that they had a medical diagnosis of an identified form of dementia. A review of resident #026's progress notes revealed there was no history of aggressive behaviours toward other residents in the past. The subsequent written plan of care from a second identified date in May 2015 identified strategies to reduce resident contact.

Interviews with registered staff #104 and the DOC confirmed that on the identified occasion resident #027 was not protected from abuse by resident #026.

The home failed to protect residents #045, #052, #048, and #027 from abuse and/or neglect by anyone.

The scope of this non-compliance is isolated as it relates to four residents. The severity is actual harm/risk. The home's Compliance History Report reveals a voluntary plan of correction (VPC) was issued on April 11, 2014. As a result of the scope, severity and the licensee's previous compliance history, a compliance order is warranted. (513)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 29th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ariel Jones

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