Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 30, 2015	2015_347197_0031	O-002471-15	Complaint

Licensee/Titulaire de permis

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

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

REACHVIEW VILLAGE
130 REACH STREET UXBRIDGE ON L9P 1L3

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

JESSICA PATTISON (197), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 14-17, 21, 22, 29, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Registered Dietitian, a Physician, the Food Service Manager, the Physiotherapist, a Physiotherapist Assistant, the Pain Consultant Nurse, the RAI-Coordinator, the Recreation Manager, Residents and a Resident's family members.

The inspectors observed resident care including staff-resident interactions, medication pass, snack pass and dining service and reviewed residents health care records, a call point duration report, minutes from registered staff meeting (March 9, 2015), Medication incident reports, release of responsibility for leave of absence with medication form, compliance history and policies related to weights, medication administration and pain management.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that the home did not ensure that their policy related to height and weight measurement was followed to ensure accuracy of resident weights.

O. Reg. 79/10, s. 68(2)(e) states that every licensee of a long-term care home shall ensure that the organized program of nutrition care and dietary services includes a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter.

The home's Height Measurement and Weight Management policy #LTC-G-60 last revised June 2014 states that Residents will be weighed and weight documented by the 7th day of each month. If a weight loss or gain of 2.0 kilograms (kg) or greater from the preceding month, the weight will be confirmed immediately.

On October 1, 2014, Resident #001's weight was noted to be 3.8kg greater than the previous month.

On November 6, 2014, Resident #001's weight was noted to be 2.6kg less than the previous month.

On April 5, 2015, Resident #001's weight was noted to be 2.9kg less than the previous month.

On June 4, 2015, Resident #001's weight was noted to be 2.8kg greater than the previous month. A progress note by the Registered Dietitian states that the weight for June 2015 was noted to be with shoes on and was not accounted for when documented.

No re-weigh was completed for Resident #001 in October 2014, November 2014, April 2015 or June 2015.

On March 1, 2015, Resident #004's weight was noted to be 13.8kg greater than the previous month. The Registered Dietitian wrote in a progress note that she queried the accuracy of the March weight as no re-weigh was noted.

On July 1, 2015, Resident #004's weight was noted to be 3.2kg less than the previous month.

No re-weigh was completed for Resident #004 in March 2015 or July 2015.

On September 15, 2015, a phone interview was conducted with the Registered Dietitian. She stated that she started working in the home on April 2, 2015. She confirmed that there had been issues with the accuracy of some resident weights and that re-weighs were not always being done as per the home's policy. She stated that she provided education to direct care staff in July 2015, which included information on how weights are to be taken (on bath days with clothing and shoes removed) and that re-weighs must be done immediately for any weight variance of 2.0 kg or more. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to comply with O. Reg. 79/10, s.8 (1)(b) in that the home did not ensure that their policy related to pain management was followed to ensure an individualized approach to pain identification and management.

O. Reg. 79/10, 48. (1) 4 states that the licensee shall ensure that an interdisciplinary program for pain management is developed and implemented in the home to identify pain in residents and manage pain.

The home's "Pain Assessment and Symptom Management" policy #LTC-E-80 (last revised August 2012) states under assessments:
On admission, the nurse will screen the resident for past history of pain and the management of that pain. If pain is identified on admission, or the resident has a diagnosis which could result in pain, and/or is receiving regular pain medication, a pain monitoring tool will be initiated for a minimum of 72 hours. After 72 hours, if further information is required to manage the resident's pain, a "Pain Assessment Inventory " will be completed. If the resident complains of pain, a quick pain assessment on the resident will be completed using PQRST and documented. The resident's pain will be measured using a standardized, evidence – informed clinical tool.
Under Pain Monitoring: Initiate pain monitoring tool when: new regular pain medication is ordered; there is a dosage increase or decrease of a regular pain medication; pain medication is discontinued; PRN pain medication is used for 3 consecutive days.

1. Resident #007 was admitted to the home with a specified diagnosis. During an interview on September 29, 2015, Resident #007 indicated having pain daily. During an interview, RPN #103 indicated Resident #007 did not report pain. Review of Resident #007's progress notes for a specified period indicated Resident #007 did not have verbal reports of pain since admission. Review of the Medication Administration Record (MAR)

indicated Resident #007 receives a specified medication once daily for pain. A documented statement from RPN #121 indicated no pain assessment was completed for Resident #007 since admission, contrary to the home's policy that states on admission the nurse will screen the resident for past history of pain and the management of that pain.

2. Resident #001 was admitted to the home with specified diagnoses. During an interview on September 16, 2015 by Inspector #197, Resident #001's main concern was pain. Resident #001 indicated that pain medication does help, but that he/she cannot get it when requested due to the scheduling of the medication.

Review of Resident #001's Pain Assessment Inventory from a specified date indicated that Resident #001 had chronic pain prior to admission. There was no other "Pain Assessment Inventory" for a period of 18 months.

Review of Resident #001's MDS assessments from two specified dates related to pain, identified Resident #001 as "continually seeking pain medication daily and no referral was required".

Review of Resident #001's progress notes for a specified period, indicated Resident #001 was experiencing pain. Resident #001 requested stronger pills on multiple occasions.

Review of Resident #001's MAR for a specified period indicated the following:

- Over a 58 day period, a PRN pain medication was required 110 times. Resident #001 received an average of two to three tablets daily and the PRN medication was noted to be effective fifty to seventy five percent of the time.

After this 58 days period, the PRN pain medication every 4 hours was decreased to a lower dosage every 4 hours.

- For the next 42 days, the PRN pain medication was required 93 times. Resident #001 received an average of two tablets daily and the PRN medication was noted to be effective an average of seventy five percent of the time.

After the 42 days period, the regular pain medication order was increased and the PRN order was changed.

Resident #001 was presenting with ongoing pain, requiring PRN pain medication almost daily for three consecutive months with moderate effect. Contrary to the home's policy and confirmed by the Director of Care, there is no evidence that a pain assessment was completed following the MDS assessment, that a quick pain assessment tool was completed, or that Resident #001's pain was measured using a standardized, evidence informed clinical tool until a specified date.[s. 8. (1) (b)]

3. The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that the home did not ensure that their policy related to medication administration was followed to ensure safe, effective and ethical administration of medications.

O. Reg. 79/10, 114. (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction, and disposal of all drugs used in the home.

The home's Medication / Treatment Standards policy #LTC-F-20 last revised August 2012 states under National Operating Procedure:
All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. Medication refused, discontinued, or not administered will be disposed of according to jurisdictional requirements.

1. Review of Resident #001's Medication Administration Record (MAR) for a specified date at 1700 hours indicated RPN #119 did not document the administration of a medication. During an interview, RPN #119 indicated she must have forgotten to sign the electronic medication record for the PRN medication after administration.

2. Review of Resident #001's Treatment Administration Record (TAR) for a specified date, indicated a Physician's order for a topical rub to be applied 3 times a day for pain relief. Review of Resident #001's TAR indicated that on a specified date, RPN #109 signed the topical rub as administered at 1600 hours. Review of the Point of Care documentation for Resident #001 completed by PSW #120, indicated that on this date at 1600 hours, PSW #120 signed that a different medicated cream had been administered. During an interview, RPN #109 and PSW #120 indicated they had not applied either cream to Resident #001.

3. Review of Resident #009's health care record indicated a Physician's order for a specified cream twice daily as needed. On September 21, 2015, interviews with PSW #117 and RPN #113 indicated that Resident #009's required the cream and that it had been applied on that day. In an interview on September 29, 2015, RPN #122 indicated that he had been applying the specified cream to Resident #009. Review of Resident #009's TAR from September 1 to 22, 2015 indicated that the specified cream was not signed as administered by RPN #122.

4. On September 29, 2015, a medicated creams for Resident #001, Resident #012 and Resident #010 were found in the Cardinal Court Spa room. During an interview, RPN #121 indicated these treatment creams were no longer ordered by the Physician and should no longer be located in the spa room.

During an interview, the DOC indicated that the PSW's apply the treatment creams and the registered staff are responsible to ensure the residents' treatment creams are applied as ordered and that the administration is documented. She also stated that the registered staff are to ensure any discontinued treatment creams are removed from the spa rooms. [s. 8. (1) (b)]

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 to ensure that staff are aware of and follow the home's policy related to weight measurement so that accurate weights are documented for each resident, to be implemented voluntarily.

WN #2: 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 comply with O. Reg. 79/10, r.131(1) and (2) in that the home did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of Resident #001 Physician orders showed specific dosages to be given for certain medications.

Review of Resident #001's Medication Administration Record (MAR) indicated that a prescribed medication was not given as prescribed on three occasions.

Review of Resident #001's Treatment Administration Record (TAR) for a four month period indicated that a medicated cream was signed for as being administered on a regular basis during the identified four months.

During an interview, RPN #103 indicated she was not aware that the medicated cream had not been received from the Pharmacy and she was not aware that another product was being used as a substitute for the medicated cream that was ordered until recently.

During an interview, the Director of Care (DOC) confirmed that Resident #001's medicated cream was not received as ordered by the Physician.

During an interview on September 22, 2015, the Physician indicated he was not aware that the medicated cream had not been provided by the Pharmacy for the specified period of time. The Physician also indicated he was not aware another product had been used in its place.[s. 131. (2)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care related to pain was not provided to Resident #001 as specified in the plan.

Review of Resident #001's progress notes for a specified period of time indicated that Resident #001 was experiencing pain. Resident #001 requested stronger pills on multiple occasions.

Review of Resident #001's care plan related to management of pain, indicated a goal for the pain to be at a tolerable level. Interventions related to pain management were to notify MD/NP of any new changes in pain status and for pain to be assessed using an appropriate monitoring tool.

Review of the clinical documentation, the medication administration record and interviews with registered staff and the DOC, all indicated that Resident #001 received PRN analgesic on a regular basis, but was not assessed for pain using an appropriate monitoring tool, as directed in Resident #001's care plan. (601)[s. 6. (7)]

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. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 52(1)2 in that the pain management program must provide strategies to manage pain including non-pharmacological interventions, equipment, supplies, devices and assistive aids.

The home's pain management program, described in the policy, "Pain Assessment and Symptom Management" LTC-E-80, (Revised August 2012) does not include any strategies to manage pain or non-pharmacologic interventions, equipment, supplies, devices and assistive aids as strategies to manage pain. [s. 52. (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 to ensure that the pain management program provides for strategies to manage pain including non-pharmacological interventions, equipment, supplies, devices and assistive aids, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that specified weight changes were not assessed using an interdisciplinary approach.

On a specified date, Resident #001 was identified as having an 8.4 per cent increase in body weight over one month. Resident #001's health care record was reviewed and there was no evidence of an assessment related to this weight change.

On a specified date, Resident #001 was identified as having a 5.3 per cent decrease in body weight over one month. Resident #001's health care record was reviewed and there was no evidence of an assessment related to this weight change.

After the specified weight changes above, the Food Service Manager completed a Quarterly Nutritional Assessment related to Resident #001. There was no mention in this assessment of the Resident's weight changes for the specified months. This assessment indicated the Resident's Goal Weight Range and that current weight is below this range. The plan indicated that no changes were made at the time.

On another date, Resident #001 was identified as having a 14.1 per cent decrease in body weight over six months, a 9.3 per cent decrease in body weight over three months and a 6.5 per cent decrease in body weight over one month. Resident #001's health care record was reviewed and there was no evidence of an assessment related to this weight change. The next nutritional assessment for Resident #001 was a quarterly dietary/HIGH nutritional risk assessment, completed by the Registered Dietitian

approximately 1.5 months later.

The home's Height Measurement and Weight Management policy #LTC-G-60 last revised June 2014 states the following:
The weight record will be reviewed monthly. A nutrition referral to the RD will be completed and the information documented in the interdisciplinary progress notes for the following weight variances:
i. weight loss or gain of greater than or equal to 5% of total body weight over one month;
ii. weight loss or gain of greater than or equal to 7.5% of total body weight over three months;
iii. weight loss or gain of greater than or equal to 10% of total body weight over six months;
iv. any other weight change that compromises the Resident's health status.

Under the section Monitoring and Evaluation, it states that the RD is responsible to review the monthly weight report at the end of each month to ensure all significant weight changes have been addressed. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that weight changes specified in O. Reg. 79/10, s. 69 are assessed using an interdisciplinary approach, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101(2) in that licensee has not ensured that a documented record is kept related to concerns brought forward by Resident #001's family members.

Family members of Resident #001 reported to Inspector #197 that they discussed issues related to Resident #001's health in a meeting with the home on August 10, 2015.

During an interview with the Director of Care (DOC) on September 17, 2015, Inspector asked if she had any documentation related to the meeting they had with the family in August 2015. She stated at this time she was focused on another issued involving the resident and the other health concerns were not addressed. She states that she likely told the family they would deal with the other concerns at a later time. Inspector asked the DOC if she felt the family currently had a concern about Resident #001's care and the DOC stated yes, but that she had no documentation unless there was something written in the meeting notes.

Investigation notes provided to the Inspector by the DOC related to a phone meeting that occurred with the Resident's family member on August 10, 2015 indicate that the family does have other health concerns related to Resident #001. The home could not provide any further documentation to say what the home did to respond to the family and their specified concerns related to the care of Resident #001.

During an interview with the Executive Director on September 16, 2015, he provided the home's complaint log and policy. The last documented complaint from Resident #001's family was in 2013 and there was nothing recent related to the concerns brought forward to the home on August 10, 2015. [s. 101. (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 to ensure that the licensee keeps a documented record including all components listed in O. Reg. 79/10, s. 101(2) related to concerns brought forward by Resident #001 and the resident's family members, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10, r. 135(1)(a) & (2) (b) in that the home did not ensure that every medication incident involving Resident #001 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and that corrective action is taken as necessary.

An interview with the DOC indicated that all medication incidents involving residents should have a medication incident report completed. The medication incident report was reviewed and includes an area for corrective actions taken to prevent recurrence.

Review of the progress notes for Resident #001 indicated on a specified date, the Resident's family member found a pill on the floor in the resident's room and gave it to the charge nurse. There was no documented evidence the resident was assessed or that a medication incident report was completed to indicate any corrective actions that were taken to prevent a recurrence. Interview of the DOC confirmed no medication incident report was completed for this incident.

Interview of Resident #001's family member indicated that two pills were found in the resident's room on the floor on another date. The family member indicated the pills and a note were left for the DOC for follow up. There was no documented evidence the resident was assessed on this date. Interview of the DOC indicated that the incident was not documented in the resident's health record, a medication incident report was not completed until a later date and no corrective actions were taken.

Resident #001's family member reported to the Inspector that on another date, the family member found three pills on Resident #001's bed and notified the Executive Director by leaving the pills under the office door. Interview of the DOC indicated the medications were identified and a medication incident report was completed for this incident. The DOC indicated an educational session was provided to the nursing staff reminding them to ensure that Resident #001's pills are taken prior to walking away. There was no documented evidence in the resident's health record regarding the medication incident or to indicate the resident was assessed.

According to an email received by Inspector #197 on a specified date, Resident #001's family member visited the home that evening and found five pills in Resident #001's drawer. Resident #001's family member notified RPN #119 and they both returned to Resident #001's room and more pills were found in the resident's drawer. During an interview, the DOC indicated being aware of the pills being found in Resident #001 drawer. The DOC was not able to identify the pills or how many pills were found as Resident #001's family member had removed the pills from the home. Review of Resident #001's family member's email and photograph indicates that eighteen pills in total were found in Resident #001's drawer on the specified date. The DOC indicated that a medication incident report was not completed due to the pills being taken from the home. There is no evidence that Resident #001 was assessed following the medication incident. [s. 135.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident in the home is documented with a record of immediate actions taken to assess and maintain the resident's health and that corrective action is taken as necessary, to be implemented voluntarily.

WN #8: 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).

Findings/Faits saillants :

1. The licensee has failed comply with LTCHA 2007, s. 3(1)1 in that Resident #001's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and dignity, was not fully respected and promoted.

On a specified date at approximately 1045 hours, Inspector #197 was seated in view of Resident #001's room. At this time, Resident #001 was just outside her/his room and PSW #108 stated in a very loud voice to the resident "If you are not going to help yourself, how do you expect us to help you? The Doctor ordered that for you." The resident was observed to look down and say nothing. PSW #108 then walked away.

The following day at approximately 1130 hours, Resident #001 was interviewed related to staff interactions. At the time of the interview, the resident could not recall any specific incident that was upsetting. The resident stated that if he/she didn't like how a staff member spoke to or treated him/her, it would be reported to the Executive Director.

During an interview with the Executive Director and Director of Care, they indicated to Inspector #601 that PSW #108 should not have spoken to Resident #001 in this manner. [s. 3. (1) 1.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 40 in that Resident #001 was not dressed appropriately in clean clothing.

Inspector #197 was in the home September 14-17, 2015. Resident #001 was noted to be wearing the same clothing September 15, 16 and 17, 2015. On September 17, 2015, Resident #001's clothing was noted to be dirty.

Resident #001 was interviewed on September 17, 2015 and stated that staff provide assistance with getting dressed and that staff get clothes out of the closet in the morning.

Resident #001's care plan states that the resident will be dressed in clean clothing according to preference through to the next review, that the resident requires extensive assistance with one staff and that the resident will lift arms and legs to help staff with dressing. The care plan also states that the resident requires support for dressing as evidenced by inability to complete task on own. [s. 40.]

Issued on this 9th day of November, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PATTISON (197), KARYN WOOD (601)
Inspection No. / No de l'inspection :	2015_347197_0031
Log No. / Registre no:	O-002471-15
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 30, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	REACHVIEW VILLAGE 130 REACH STREET, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael MacDonald

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 :

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

Order / Ordre :

The licensee shall ensure that when Resident #001 and Resident #007's pain is not relieved by initial interventions, that the residents are assessed using a clinically appropriate pain assessment tool.

The licensee shall also ensure that medication is administered to Residents in accordance with the directions for use, as specified by the prescriber. Treatment medication creams shall be destructed as per policy when no longer prescribed by the Physician.

All nursing staff shall be re-educated related to the contents of the home's "Pain Assessment and Symptom Management" policy #LTC-E-80 and "Medication Administration" policy #LTC-F-20 to ensure compliance. A process shall be put into place to identify and promptly address deviation from these established policies.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, s.8 (1)(b) in that the home did not ensure that their policy related to pain management was followed to ensure an individualized approach to pain identification and management.

O. Reg. 79/10, 48. (1) 4 states that the licensee shall ensure that an interdisciplinary program for pain management is developed and implemented in the home to identify pain in residents and manage pain.

The home's "Pain Assessment and Symptom Management" policy #LTC-E-80 (last revised August 2012) states under assessments:
On admission, the nurse will screen the resident for past history of pain and the management of that pain. If pain is identified on admission, or the resident has a diagnosis which could result in pain, and/or is receiving regular pain medication, a pain monitoring tool will be initiated for a minimum of 72 hours. After 72 hours, if further information is required to manage the resident's pain, a "Pain Assessment Inventory " will be completed. If the resident complains of pain, a quick pain assessment on the resident will be completed using PQRST and documented. The resident's pain will be measured using a standardized, evidence – informed clinical tool.
Under Pain Monitoring: Initiate pain monitoring tool when: new regular pain medication is ordered; there is a dosage increase or decrease of a regular pain medication; pain medication is discontinued; PRN pain medication is used for 3 consecutive days.

1. Resident #007 was admitted to the home with a specified diagnosis. During an interview on September 29, 2015, Resident #007 indicated having pain daily. During an interview, RPN #103 indicated Resident #007 did not report pain. Review of Resident #007's progress notes for a specified period indicated Resident #007 did not have verbal reports of pain since admission. Review of the Medication Administration Record (MAR) indicated Resident #007 receives a specified medication once daily for pain. A documented statement from RPN #121 indicated no pain assessment was completed for Resident #007 since admission, contrary to the home's policy that states on admission the nurse will screen the resident for past history of pain and the management of that pain.

2. Resident #001 was admitted to the home with specified diagnoses. During an interview on September 16, 2015 by Inspector #197, Resident #001's main concern was pain. Resident #001 indicated that pain medication does help, but that he/she cannot get it when requested due to the scheduling of the medication.

Review of Resident #001's Pain Assessment Inventory from a specified date indicated that Resident #001 had chronic pain prior to admission. There was no other "Pain Assessment Inventory" for a period of 18 months.

Review of Resident #001's MDS assessments from two specified dates related

to pain, identified Resident #001 as "continually seeking pain medication daily and no referral was required".

Review of Resident #001's progress notes for a specified period, indicated Resident #001 was experiencing pain. Resident #001 requested stronger pills on multiple occasions.

Review of Resident #001's MAR for a specified period indicated the following:

- Over a 58 day period, a PRN pain medication was required 110 times. Resident #001 received an average of two to three tablets daily and the PRN medication was noted to be effective fifty to seventy five percent of the time.

After this 58 days period, the PRN pain medication every 4 hours was decreased to a lower dosage every 4 hours.

- For the next 42 days, the PRN pain medication was required 93 times. Resident #001 received an average of two tablets daily and the PRN medication was noted to be effective an average of seventy five percent of the time.

After the 42 days period, the regular pain medication order was increased and the PRN order was changed.

Resident #001 was presenting with ongoing pain, requiring PRN pain medication almost daily for three consecutive months with moderate effect. Contrary to the home's policy and confirmed by the Director of Care, there is no evidence that a pain assessment was completed following the MDS assessment, that a quick pain assessment tool was completed, or that Resident #001's pain was measured using a standardized, evidence informed clinical tool until a specified date.

The non-compliance with O. Reg. 79/10, s.8(1)(b) order was based on the application of the factors of severity and scope, keeping with two out of three residents who were experiencing pain and receiving regular pain medication were not reassessed using a standardized, evidence informed tool to identify pain.

During the complaint inspection, it was identified that Residents #001 and #007 were experiencing pain. The "Pain Monitoring Tool" and the "Pain Assessment

Inventory" were not completed when there were changes to Resident #001's pain medication, as per the home's policy indicated above.

Therefore, the residents identified have ongoing pain that has not been analyzed. In addition, the compliance history of the home from November 6, 2013 and July 30, 2014 indicated previous non-compliance (VPC) related to pain management. (601)

2. The licensee has failed to comply with O. Reg. 79/10, s. 8(1)(b) in that the home did not ensure that their policy related to medication administration was followed to ensure safe, effective and ethical administration of medications.

O. Reg. 79/10, 114. (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration and destruction, and disposal of all drugs used in the home.

The home's Medication / Treatment Standards policy #LTC-F-20 last revised August 2012 states under National Operating Procedure:
All medication administration, refused or omitted will be documented immediately after administration on the MAR/TAR using the proper codes by administering nurse. Medication refused, discontinued, or not administered will be disposed of according to jurisdictional requirements.

1. Review of Resident #001's Medication Administration Record (MAR) for a specified date at 1700 hours indicated RPN #119 did not document the administration of a medication. During an interview, RPN #119 indicated she must have forgotten to sign the electronic medication record for the PRN medication after administration.

2. Review of Resident #001's Treatment Administration Record (TAR) for a specified date, indicated a Physician's order for a topical rub to be applied 3 times a day for pain relief. Review of Resident #001's TAR indicated that on a specified date, RPN #109 signed the topical rub as administered at 1600 hours. Review of the Point of Care documentation for Resident #001 completed by PSW #120, indicated that on this date at 1600 hours, PSW #120 signed that a different medicated cream had been administered. During an interview, RPN #109 and PSW #120 indicated they had not applied either cream to Resident #001.

3. Review of Resident #009's health care record indicated a Physician's order for a specified cream twice daily as needed. On September 21, 2015, interviews with PSW #117 and RPN #113 indicated that Resident #009's required the cream and that it had been applied on that day. In an interview on September 29, 2015, RPN #122 indicated that he had been applying the specified cream to Resident #009. Review of Resident #009's TAR from September 1 to 22, 2015 indicated that the specified cream was not signed as administered by RPN #122.

4. On September 29, 2015, a medicated creams for Resident #001, Resident #012 and Resident #010 were found in the Cardinal Court Spa room. During an interview, RPN #121 indicated these treatment creams were no longer ordered by the Physician and should no longer be located in the spa room.

During an interview, the DOC indicated that the PSW's apply the treatment creams and the registered staff are responsible to ensure the residents' treatment creams are applied as ordered and that the administration is documented. She also stated that the registered staff are to ensure any discontinued treatment creams are removed from the spa rooms.

The non-compliance with O. Reg. 79/10, 8(1) (b), O.Reg. 79/10, 114.(2) order was based upon the application of the factors of severity and scope keeping with two out of three residents were identified as receiving medication without documentation following drug administration. Therefore, there is a risk of medication dispensing errors as staff had not documented the medication being given and therefore Resident #001 and Resident #009 could have potentially received the medication again. Resident #001, #010, and #012 had a potential of receiving a treatment medication cream that was no longer prescribed by the Physician. In addition, the compliance history of the home related to a similar area indicated previous non-compliance related to medication administration. (601)

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

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 : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that Resident #001's medications are administered in accordance with the directions for use as specified by the prescriber.

All nursing staff shall be re-educated related to the contents of the home's "Medication Administration" policy #LTC-F-20 and that a monitoring process is put into place to ensure that the policy is complied with.

Grounds / Motifs :

1. The licensee has failed to comply with O. Reg. 79/10, r.131(1) and (2) in that the home did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Review of Resident #001 Physician orders showed specific dosages to be given for certain medications.

Review of Resident #001's Medication Administration Record (MAR) indicated that a prescribed medication was not given as prescribed on three occasions.

Review of Resident #001's Treatment Administration Record (TAR) for a four month period indicated that a medicated cream was signed for as being administered on a regular basis during the identified four months.

During an interview, RPN #103 indicated she was not aware that the medicated cream had not been received from the Pharmacy and she was not aware that another product was being used as a substitute for the medicated cream that was ordered until recently.

During an interview, the Director of Care (DOC) confirmed that Resident #001's medicated cream was not received as ordered by the Physician.

During an interview on September 22, 2015, the Physician indicated he was not aware that the medicated cream had not been provided by the Pharmacy for the specified period of time. The Physician also indicated he was not aware another product had been used in its place.

The non-compliance with O. Reg. 79/10, r.131 (1) and (2) is being issued as a Compliance Order based on the fact that actual harm came to Resident #001. During the complaint inspection it was identified that Resident #001 was experiencing on-going pain and the medicated cream prescribed by the Physician had not been provided to the Resident. (601)

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

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. 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 all pain related interventions identified in Residents' plans of care, including Resident #001, are provided as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, s. 6(7) in that the care set out in the plan of care related to pain was not provided to Resident #001 as specified in the plan.

Review of Resident #001's progress notes for a specified period of time indicated that Resident #001 was experiencing pain. Resident #001 requested stronger pills on multiple occasions.

Review of Resident #001's care plan related to management of pain, indicated a goal for the pain to be at a tolerable level. Interventions related to pain management were to notify MD/NP of any new changes in pain status and for pain to be assessed using an appropriate monitoring tool.

Review of the clinical documentation, the medication administration record and interviews with registered staff and the DOC, all indicated that Resident #001 received PRN analgesic on a regular basis, but was not assessed for pain using an appropriate monitoring tool, as directed in Resident #001's care plan. (601)

This Compliance Order is based on the fact that during this complaint inspection it was identified that Resident #001 was experiencing pain. The plan of care for Resident #001 had interventions identified to mitigate pain that were not followed as directed in the plan. Therefore, Resident #001 continued to have on-going pain for a specified period of time. In addition, the home's compliance history was reviewed and LTCHA 2007, s. 6(7) was issued on September 20, 2013, October 28, 2013 and during the Resident Quality Inspection in July 2015. (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 09, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of October, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jessica Pattison

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