



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

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

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

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

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

**Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 19, 2014	2014_171155_0023	L-001311-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

SUMMIT PLACE
850-4TH STREET EAST, OWEN SOUND, ON, N4K-6A3

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

SHARON PERRY (155), DOROTHY GINTHER (568), TAMMY SZYMANOWSKI (165)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): September 29, 30, October 1, 2, 3, 6 and 7, 2014.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Environmental Services Manager, Programs Manager, RAI/Education Coordinator, Food Service Manager, Cook, Dietary Aide, Maintenance Man, Laundry Aide, Housekeeper, Activity Aide, Restorative Care Aide, Physiotherapy Assistant, 2 Registered Nurses, 5 Registered Practical Nurses, 11 Personal Support Workers, Resident Council Representative, 3 Family Members, and 40+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of Resident Living Areas, common areas, dining rooms, kitchen, laundry room, 2 medication rooms; observed resident care provision, resident-staff interactions, dining service, recreational activities, and medication administration; reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:



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**Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care**

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).



Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents are fully respected and promoted as 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.

During this inspection it was identified that two residents did not have their rights fully respected and promoted as they were not treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity. [s.3. (1)1.]

2. The licensee of the long term care home failed to ensure that the rights of residents are fully respected and promoted as every resident has the right to be protected from abuse.

During this inspection it was identified that six residents did not have their rights fully respected and promoted as they were not protected from abuse.

The home failed to ensure that every resident was protected from abuse. [s. 3. (1) 2.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessment and interventions and that the resident's responses to interventions are documented.

1. Staff confirmed that an identified resident was demonstrating responsive behaviours.

There was no evidence that strategies were developed and implemented to respond to these behaviours and that actions taken including interventions and resident's responses to interventions were not documented.[s. 53. (4)]

2. The plan of care for an identified resident revealed that behavioural triggers for the resident were not identified. Strategies were not developed and implemented to respond to these behaviours, and actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to the interventions were not documented. [s. 53. (4)]

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

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Record review revealed that an identified resident had a fall. The Resident Assessment Protocol for Falls triggered by the Minimum Data Set (MDS) Assessment indicates that the resident has had one unwitnessed fall this review with no injury. It further states that falls would be addressed in the care plan with the objective to slow or minimize decline, minimize risks, and avoid complications.

Record review did not provide evidence of a written plan of care related to falls risk. Staff confirmed that there was no written plan of care pertaining to falls risk for the resident. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Staff interview revealed that an identified resident walks in their room with the assistance of one staff but on occasion will get up on their own. Staff indicated that the resident did not use any ambulatory aides when walking. The resident's care plan for transfers and mobility indicate that the resident uses a walker to transfer and ambulate. Registered staff confirmed that the plan of care for transfers and mobility does not provide clear directions to staff who provide direct care to the resident. [s. 6. (1) (c)]



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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Revera policy LTC-E-60, Fall Interventions Risk Management (FIRM) Program revised March 2014 indicates that the Substitute Decision Maker (SDM) will be notified of all falls. Staff interview with the RAI Coordinator revealed that post fall, staff document that they have notified the resident's SDM in the risk management assessment or the interdisciplinary progress notes.

Record review revealed that an identified resident had a fall. There was no evidence in the resident record that resident's SDM was notified of this fall. Staff confirmed that resident's SDM was not notified of the resident's fall. [s. 8. (1) (a),s. 8. (1) (b)]



Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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, is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

- s. 15. (2) Every licensee of a long-term care home shall ensure that,**
- (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
 - (b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
 - (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

Findings/Faits saillants :



1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

a) It was noted that the five ceiling vents were dusty. The Environmental Services Manager confirmed that the vents were dusty and needed to be cleaned.

b) An identified resident's wheelchair was noted to have dried food and debris on chair. The registered staff confirmed that the wheelchair is to be cleaned monthly and when necessary. They also confirmed that the wheelchair was in need of cleaning. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Observations, throughout the RQI, revealed:

a) Flooring in the centre core hallway by the activity room is cracked at the seam.

b) Wall under window in the north tub room is damaged.

c) Radiator on the wall in the south tub room is held together by duct tape.

d) Cupboards and counter top in the north medication room are damaged.

e) Paint and minor wall damage at head of the bed. Baseboard missing at head of the bed.

f) Light cover hanging off ceiling light in bathroom.

g) Three rooms noted to have paint and wall damage in bathroom.

h) Top of the night stand has laminate missing at the edge and press board is exposed.

i) Top of the night stand has laminate missing at the edge and press board is exposed. Wall in bathroom patched but not painted. Paint and wall damage to wall at foot of bed.

j) Baseboard in bathroom is coming off the wall.

k) Baseboard missing on the wall to the left at the head of the bed and baseboard in bathroom is coming off the wall.

During a tour of the home, the Environmental Services Manager confirmed the identified deficiencies and the expectation is the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]



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 home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 26. Whistle-blowing protection

Specifically failed to comply with the following:

s. 26. (5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):

1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110. 2007, c. 8, s. 26 (5).

2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation. 2007, c. 8, s. 26 (5).

3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129. 2007, c. 8, s. 26 (5).

4. A staff member. 2007, c. 8, s. 26 (5).

Findings/Faits saillants :



1. The licensee failed to ensure that a staff member shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from disclosing anything to an inspector.

An identified resident reported an incident to an inspector. After an inspection of the incident, the Director of Care reported that they spoke with the staff member and documented the incident on their record.

The identified resident informed the inspectors that a staff had made comments to them regarding reporting the incident to the inspectors. The Executive Director reported that the expectation of the home was that staff members did not speak with a resident regarding an incident that a resident reported.

The staff members discussion with the resident related to the incident had the effect of discouraging the resident from disclosing anything to an inspector. [s. 26. (5) 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 none of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1)(a) to (c):
4. A staff member, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :



1. The licensee has failed to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.

An identified resident was observed with a restraint in place. Record review revealed that the restraint was applied prior to the physician ordering or approving the restraint.

Registered staff confirmed that it is the Home's expectation that the physician's order is obtained prior to the restraint being applied. [s. 31. (2) 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 the restraining of a resident by a physical device may be included in a resident's plan of care only if a physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (2) The licensee shall ensure that each menu, (b) provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time. O. Reg. 79/10, s. 71 (2).

Findings/Faits saillants :



1. The licensee has failed to ensure that each menu, provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time.

The home's planned menu for the week of September 29, 2014, had a substitution for Monday's lunch meal from a mini sub sandwich to an assorted deli meat and tomato sandwich. It was observed during the meal that ham and turkey were used for the deli meat which was confirmed by a dietary aide. Sliced turkey sandwiches were served for Tuesday's lunch meal and a deli meat salad plate that included turkey and ham was served for Wednesday's lunch. The Food Service Manager confirmed that the menu items were served for three consecutive days and reported that roast beef should have been served for the deli meat salad plate on Wednesday.

Interview with residents identified that variety of food was lacking with similar items being served repeatedly. Residents confirmed that this weeks lunches did not provide variety, reported that some times things are repeated on the same day from week to week and felt that the home did not have enough variety . [s. 71. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each menu provides for a variety of foods, including fresh seasonal foods, each day from all food groups in keeping with Canada's Food Guide as it exists from time to time, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service



Specifically failed to comply with the following:

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

7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

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

8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that included, at a minimum, sufficient time for every resident to eat at his or her own pace.

Several residents interviewed reported that they are rushed during meal times and they did not feel they had sufficient time to finish their meals.

A review of the home's Resident Food Committee Minutes dated August 28, 2014, indicated that residents voiced concerns related to staff rushing the clean up especially during second sitting meals. The minutes indicated that residents were feeling they did not have enough time to eat. This was verified by the Food Service Manager. [s. 73. (1) 7.]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During observation of the lunch meal several residents were observed eating their soup with their main entree already placed in front of them. It was also observed that some residents that were still eating their main entree had dessert served.

The Food Service Manager verified that course by course was not always completed in dining service. [s. 73. (1) 8.]



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 home has a dining and snack service that includes, at a minimum, sufficient time for every resident to eat at his or her own pace and course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart,

(i) that is used exclusively for drugs and drug-related supplies,

(ii) that is secure and locked,

(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and

(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).

(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, and is secure and locked.

A medication cart was unlocked and unattended in the hall outside the dining room. The registered staff was in the Activity Room and the medication cart was not in visual proximity. The registered staff confirmed that the medication cart was unlocked and unattended.

It was observed during different times that the Director of Care's office door was open and no one was in attendance. The vaccine fridge was located in the office and noted to contain Tubersol and Pneumovax medications and two eggs.

The Director of Care confirmed that her door was open and medications were not stored in an area that was secure and locked. She also confirmed that her eggs were her lunch and removed them when questioned. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, and that is secure and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :



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

During stage one of the inspection it was observed by inspector #155, #568 and #165 that several residents toothbrushes located in shared bathrooms were not labelled.

On October 1, 2014, the Infection Prevention and Control Lead observed with the inspector several unlabelled toothbrushes located in shared bathrooms. Unlabelled combs, nail file and denture containers were also observed. The Infection Prevention and Control Lead confirmed that all the items including the toothbrushes were to be labelled and the toothbrushes were discarded. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :



1. The licensee failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On September 30, 2014 observation of an identified resident's room revealed that the window opened more than 36 centimetres.

Staff interview with the Environmental Services Manager on September 30, 2014 confirmed that the window lock was broken and that the window opened more than the limit of 15 centimetres. The Environmental Services Manager repaired the window to ensure that it would not open beyond 15 centimetres. [s. 16.]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 17.

Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).

(b) is on at all times; O. Reg. 79/10, s. 17 (1).

(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).

(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).

(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).

(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :



1. The licensee has failed to ensure that the resident-staff communication and response system is on at all times.

On September 29, 2014 at 1434 hours an identified resident's call bell in their bedroom was not functioning. Staff confirmed that the call bell was not functioning and stated that they would report it immediately to the maintenance staff. At 1515 hours the call bell was functioning. [s. 17. (1) (b)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature in the home is maintained at a minimum of 22 degrees Celsius.

On October 1, 2014 at 1440 hours the temperature in the hallway was 21 degrees Celsius. The registered staff confirmed that the hallway felt cool and noted a resident sitting all covered up with a blanket.

On October 3, 2014 at 1115 hours the temperature in the activity room was 21 degrees Celsius. The Executive Director confirmed the cool air in the room and reported it to the Maintenance Manager. [s. 21.]

WN #15: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian who is a member of the staff of the home.

An identified resident was exhibiting altered skin integrity. Record review revealed that there was no assessment by a registered dietitian. The registered staff confirmed that the dietitian has not assessed the resident and that the expectation of the home is that the dietitian assesses residents with altered skin integrity. [s. 50. (2) (b) (iii)]



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

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

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

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

Issued on this 20th day of November, 2014

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



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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : SHARON PERRY (155), DOROTHY GINTHER (568),
TAMMY SZYMANOWSKI (165)

Inspection No. /

No de l'inspection : 2014_171155_0023

Log No. /

Registre no: L-001311-14

Type of Inspection /

Genre

d'inspection:

Resident Quality Inspection

Report Date(s) /

Date(s) du Rapport : Nov 19, 2014

Licensee /

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

LTC Home /

Foyer de SLD : SUMMIT PLACE
850-4TH STREET EAST, OWEN SOUND, ON,
N4K-6A3

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : CINDIE HOLM



**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*

**Ministère 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*

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(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # /**Ordre no :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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

Order(s) of the Inspector

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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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

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other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee 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 in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.

Grounds / Motifs :



**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*

**Ministère 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*

1. During this inspection it was identified that two residents did not have their rights fully respected and promoted as they were not treated with courtesy and respect in a way that fully recognized their individuality and respected their dignity.

The home failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

(165)

2. During this inspection it was identified that six residents did not have their rights fully respected and promoted as they were not protected from abuse.

The home failed to ensure that every resident was protected from abuse. (165)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2014



**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

**Ministère de la Santé et
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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. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(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).

Order / Ordre :

The licensee shall ensure that the behavioural triggers are identified; strategies are developed and implemented to respond to these behaviours; and 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, for two identified residents and any other residents with responsive behaviours.

Grounds / Motifs :



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

Ordre(s) de l'inspecteur

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1. The plan of care for an identified resident revealed that behavioural triggers for the resident were not identified. Strategies were not developed and implemented to respond to these behaviours, and actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and the resident's responses to the interventions were not documented. (165)

2. Staff confirmed that an identified resident was demonstrating responsive behaviours.

There was no evidence that strategies were developed and implemented to respond to these behaviours and that actions taken including interventions and resident's responses to interventions were not documented.

(568)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2014



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

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

Order(s) of the Inspector

Pursuant to section 153 and/or
section 154 of the *Long-Term Care
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Ordre(s) de l'inspecteur

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de l'article 154 de la *Loi de 2007 sur les foyers
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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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



**Ministry of Health and
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**Ministère de la Santé et
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Ordre(s) de l'inspecteur

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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.



**Ministry of Health and
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Pursuant to section 153 and/or
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Ordre(s) de l'inspecteur
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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, 11^e 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.



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

**Ministère de la Santé et
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de l'article 154 de la *Loi de 2007 sur les foyers
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En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

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

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

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

Issued on this 19th day of November, 2014

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : SHARON PERRY

Service Area Office /

Bureau régional de services : London Service Area Office