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
Feb 27, 2015	2014_246196_0017	S-000353-14	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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

LAUREN TENHUNEN (196), DEBBIE WARPULA (577), MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 22, 23, 24, 25, 26, 29, 30, October 1, 2, 3, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), Recreation staff members, RAI Coordinator, Dietary staff, Maintenance staff, Housekeeping staff,Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

16 WN(s)
5 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #002	2013_211106_0027	106

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's physical functioning and the type and level of assistance required for activities of daily living, specifically hygiene and grooming. O. Reg. 79/10, s. 26 (3).

On October 2, 2014, Inspector #106 reviewed the printed plan of care found in the care plan binder, the most recent version of the plan of care found in the resident's electronic chart and the Kardex for Resident #020 and none of these documents provided staff with direction on the type and level of assistance required for activities of daily living, including hygiene and grooming. [s. 26. (3) 7.]

2. On October 2, 2014, Inspector #106 reviewed the printed plan of care found in the care plan binder, the most recent version of the plan of care found in the resident's electronic chart and the Kardex for Resident #022 and none of these documents provided staff with direction the type and level of assistance required for activities of daily living, including hygiene and grooming. [s. 26. (3) 7.]

3. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions, specifically risk of falls. O. Reg. 79/10, s. 26 (3).

In 2014, Resident #029 was admitted to the home. A Physiotherapy Assessment note was created on the day of admission, which indicated that the resident's overall risk of

falls was high. A "Falls Risk Assessment Tool - FRAT (2013)" was also completed on the day of admission and it indicated that the resident scored 14 and was a medium risk for falls.

The "Resident Admission Assessment/Plan of Care" for Resident #029 was reviewed and other than the resident's name, room number, sex, date of birth and allergies, no other information was completed. On September 29, 2014, Inspector #106, asked the RAI Coordinator, where the initial plan of care is documented, the RAI Coordinator indicated that staff were to document the initial plan of care on the "Resident Admission Assessment/Plan of Care" document and that is what is used as the resident's plan of care until the plan of care is completed after up to 21 days.

The falls section of the residents plan of care was not completed until fifteen days after admission. For the first 15 days since admission, the resident did not have any interventions in their plan of care to prevent falls, even though the physiotherapy assessment indicated that they were a high risk to fall. [s. 26. (3) 10.]

4. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions, specifically risk of falls. O. Reg. 79/10, s. 26 (3).

A Critical Incident report was submitted to the Director in 2014 outlining a series of falls and subsequent injury requiring transfer to hospital for Resident #046.

On September 30, 2014, the health care record for Resident #046 was reviewed for information regarding falls and risk for falls. This resident was admitted to the home in 2014 and the initial "Falls Risk Assessment Tool - FRAT (2013)" completed on the day of admission, identified Resident #046 to be a medium risk for falls.

On September 30, 2014, an interview was conducted with #S-103 regarding the current care plan for Resident #046 related to risk for falls. It was confirmed to the inspector, that this resident has had several falls since admission to the home, but that the care plan remained unchanged. A total of six falls had occurred.

A falls risk assessment (FRAT) was completed after each of these falls and identified Resident #046 to be at high risk for falls. Despite being at a high risk for falls, and having six falls, no revisions were made to the plan of care.

Resident #046, as a result, sustained a serious injury after the latest fall. [s. 26. (3) 10.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

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

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

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Dining service was observed on September 22, 2014, on a specific unit by Inspector #196. At 1231hrs, Resident #080 was provided with a piece of carrot cake by #S-100 and after placing it in front of the resident, this staff asked #S-101 if this resident could have a piece of cake as the dietary aid had provided it for this resident. #S-101 reported that Resident #080 was on a pureed diet and could not have a piece of cake. #S-100 was observed to remove the cake and provide a bowl of pudding instead.

The dietary reference sheet with print date of June 17, 2014, was reviewed and it indicated a "Puree" diet for Resident #080. The diet/fluid record as found posted on the wall in the servery identified this resident as on a "minced texture" diet.

The current care plan as found online in Point Click Care under the focus of Nutritional risk includes the intervention of "Provide High Calorie/High Protein diet-soft texture, regular fluids". Staff were unaware of the texture of the diet this resident was to receive and the dietary reference sheet, the diet/fluid record and the care plan gave conflicting information. [s. 6. (1) (c)]

2. The most recent care plan document found on the computer and the Kardex for Resident #026 both indicated that the resident requires the physical assistance of 2 persons to transfer and the resident requires a transfer belt to transfer. The care plan document that was found in the care plan binder on September 26, 2014, indicated that the resident requires the assistance of one person to transfer and uses a walker to transfer.

On October 2, 2014, Inspector #106, interviewed #S-102 and they reported that the resident requires the assistance of 2 staff members to transfer. The care plan document found in the care plan binder provides different direction to staff as compared to the care plan found on the computer and the Kardex. [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences.

The most recent care plan document, found on the computer for Resident #021, indicated "(#021) does have upper and lower dentures. Staff will do proper oral care with (#021) to ensure their teeth are as clean as they can be". The Kardex that was printed in September 2014, also indicated the resident has dentures. The RAI MDS assessment from June 2014, indicated that Resident #021 had dentures and/or removable bridge.

On October 1, 2014, Inspector #106 interviewed a PSW and a RN, and both staff members reported that Resident #021 does not have dentures and has small tooth stumps, from previous dental work. The PSW told the inspector that the resident's mouth is cleaned with swabs and the RN told the inspector that they did not recall the resident ever having dentures.

No assessments of Resident #021's oral status were found in the resident's plan of care. [s. 6. (2)]

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

On September 30, 2014, the health care records for Resident #046 were reviewed. This resident was identified as having a significant change in their health status upon return from hospital. As a result of this change, an assessment was done by a specialist in 2014, and new interventions were implemented to the texture of the diet, specifically, regular/minced. This was discussed with #S-103 and was confirmed that this change was not reflected in the care plan and it was reported that the registered staff working on the day the order was received, would have been responsible for changing the care plan. [s. 6. (4) (b)]

5. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

On a day in September 2014, Inspector #577 met with Resident #003 and it was reported that they had told #S-105 that they did not want #S-104 involved in their care. On September 29, 2014, Inspector #577 spoke to #S-104 and they reported Resident #003 had requested no male staff since last week and they were complying with their wishes. Inspector #577 reviewed the resident's care plan and noted that the resident's request is not included in the plan of care.

On September 30, 2014, Inspector #577 spoke with #S-105 concerning the complaint from Resident #003 and it was confirmed that this resident had requested that #S-104 not be involved in their care and this was then reported to the RN working that shift. On

September 30, 2014, Inspector #577 reviewed the progress note as documented by #S-105, which identified that this resident requested not to have this staff provide care for them.

On October 1, 2014, Inspector #577 interviewed #S-106 and informed them of Resident #003's request not to have this PSW involved in their care. According to #S-106, they had become aware of the request the day prior and that this information should have been documented in the care plan. On October 2, 2014, Inspector #577 reviewed the resident's care plan and noted that the resident's request was not included in the plan of care. [s. 6. (5)]

6. The licensee has failed to ensure that that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

A Critical Incident was submitted to the Director in 2014, outlining a fall with injury for which Resident #046 was taken to hospital and had resulted in a significant change to their health status. The resident had a series of four falls over a two day period and it was documented in the progress notes that the Substitute Decision Maker (SDM) was informed of each fall occurrence. The progress notes documented, outlined an assessment of the resident, which included a loss of consciousness for approximately 1.5 minutes after falling backwards and hitting the back of their head. According to an interview with the SDM, they reported that they were not informed that after this particular fall, Resident #046 had become unconscious for a period of time.

An interview was conducted with #S-106 and it was confirmed that the Substitute Decision Maker (SDM) was not made aware of Resident #046's loss of consciousness after the fall. The SDM was notified of the loss of consciousness by #S-107 the following morning, when their family member was sent to hospital for assessment and treatment. [s. 6. (5)]

7. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. 2007, c. 8, s. 6 (10).

A Critical Incident report was submitted to the Director in 2014 and outlined that Resident

#029 was transferred and admitted to hospital after falling and sustaining an injury. After return from hospital, the following intervention was put in the resident's plan of care, "Compression stocking worn at all times to prevent DVT".

On October 2, 2014, Inspector #106 observed Resident #026 laying in bed and they did not have the compression stocking applied. On October 2, 2014, the Inspector interviewed #S-102, and it was reported that the resident only wore the stockings when they returned from hospital and they no longer wear them, and had not worn them since approximately the middle of September 2014. [s. 6. (10) (b)]

8. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. 2007, c. 8, s. 6 (10).

On October 3, 2014, Inspector #106 interviewed a RPN and a PSW, regarding resident #022 and asked each staff member separately, what responsive behaviours this resident displays. Both staff members indicated that the resident does not have responsive behaviours and even after the inspector asked if resident #022 displays any responsive behaviours when the resident is incontinent of stool, they both reported that the resident does not display any responsive behaviours.

The most recent care plan document found on the computer has a focus titled, "RESPONSIVE BEHAVIOURS and included reference to responsive behaviours exhibited when incontinent of stool. The RAI MDS assessment from 2014, indicated no behavioural symptoms present and there was no change in behaviour in the last 90 days. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002, 003 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. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

A Critical Incident report was submitted to the Director in 2014 for an alleged staff to resident verbal and physical abuse incident. According to the report, #S-121 was witnessed to use foul language towards Resident #082 and to be physically rough with this resident during the provision of care.

On September 30, 2014, an interview was conducted with the Administrator of the home regarding the incident and the home's investigation. During the interview, the investigation notes were reviewed and a separate incident was identified, in which this same staff member #S-121 had verbally abused Resident #083 the evening before. This incident was witnessed by #S-103 but was not reported to the Administrator until four days later and the incident was never reported to the Director.

The home's investigation determined that verbal abuse towards Resident #082 had occurred and as a result #S-121 received a one day unpaid suspension and a letter of discipline. In addition, the letter included reference to the other verbal abuse incident that had occurred the previous evening.

#S-121 was witnessed to verbally abuse Resident #083 and it was not reported to management until four days later. In addition, this incident was never reported to the Director. A second incident of witnessed verbal abuse from staff member #S-121 towards Resident #082 occurred and was not reported to the management nor the Director until four days later. 2015. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1).

A Critical Incident report was submitted to the Director in 2014 outlining an incident of alleged staff to resident verbal abuse which had occurred.

On September 30, 2014, an interview was conducted with #S-103 and it was reported that on a particular evening, two separate incidents had been brought forward by staff working that shift and #S-103 encouraged them to document the information and then it was reported to the Administrator the following day. An interview was conducted with the Administrator on September 30, 2014, and it was not known why there was a delay in reporting to the Director.

#S-103 was aware of an allegation of verbal abuse from a staff member to a resident, the Administrator was made aware two days later, yet the Director was not until 5 days after the incident.[s. 24. (1)]

2. The licensee has failed to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1).

A Critical Incident report was submitted to the Director in 2014 for an alleged staff to resident verbal and physical abuse incident. According to the report, #S-121 was witnessed to use foul language towards Resident #082 and to be physically rough to this resident during the provision of care. The Director was not notified immediately as required.

In addition, another incident of verbal abuse was witnessed to have occurred on a specific evening by #S-121 towards Resident #083 and it was not reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On four days of the inspection, on a resident unit, Inspector #577 noted a lingering odour of urine in a shared washroom in a resident's room. In addition, the washroom floor around the toilet was stained, the floor was sticky and an unlabelled blue urinal was on the washroom counter.

During inspection, Inspector #577 noted a lingering odour of urine in a shared washroom in a resident's room. An unlabelled blue urinal was on the back of the toilet.

During inspection, Inspector met with #S-108 and they reported there were sufficient housekeeping and cleaning supplies readily available to all staff at the home. They also reported that there are problematic rooms that have odours and sometimes even after a deep cleaning of a room, lingering odours may exist due to urine seeping under toilets. Inspector #577 conducted an interview with #S-109 who reported that smells can be caused from urine under the floor mats that are routinely cleaned, urine has stained the floors and also that used urinals cause odours. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that (a) drugs are stored in an area or a medication cart (iv) that complies with manufacturer's instructions for the storage of the drugs; O. Reg. 79/10, s. 129 (1).

During inspection, on a resident unit, Inspector #577 observed the medication cart and the following expired medications were found in the cart: Risperidone 0.5 mg expired August 2011, Nitrospray 0.4 mg expired June 2014, Salbutamol inhaler expired April 2014 and a tube of unlabelled Ambesol gel expired August 2014. In addition, expired stock medication was located in an unlocked storage cupboard in the medication room and included: Buckley's cough syrup expired April 2014, Ambesol liquid expired March 2014, Tylenol Extra Strength 2 bottles expired November 2011, Isopto Tears expired March 2014.

Inspector #577 reported the expired medication to #S-110 and they reported the process for expired medication is to place them in waste bucket, labelled 'Waste pharmaceutical' under the sink and a company will pick them up and that there wasn't a process for checking expiry dates on medication. [s. 129. (1) (a)]

2. The licensee has failed to ensure that (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).

During inspection, Inspector #577 observed a medication cart on the second floor of the home that had 2 unlocked narcotic storage areas. This was brought to the attention of #S-110 and they proceeded to lock them.

During inspection, Inspector #577 reviewed Revera's Medication policy "Management of Narcotic and Controlled Drugs" LTC-F-80 and it indicated that 'All narcotic and controlled drugs will be secured by double locking' and 'Narcotic drawers/containers will be locked at all times in the medication carts'. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that that (a) drugs are stored in an area or a medication cart (iv) that complies with manufacturer's instructions for the storage of the drugs and (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the Infection Prevention and Control program. O. Reg. 79/10, s. 229 (4).

During inspection, at 1215hrs, Inspector #196 observed #S-111 remove dirty plates from residents that had finished eating their meal and then proceeded to assist another resident with their meal and hand hygiene was not observed between these tasks. [s. 229. (4)]

2. During inspection, at approximately 1710hrs to 1730hrs, Inspector #106 observed part of the dining service in a resident unit. During the observation, the inspector observed 3 PSWs transition between assisting residents with eating, serving residents desserts, clear dirty dishes and assist residents with wiping their face and hands with wet cloths. None of the PSWs were observed to practice hand hygiene after clearing dirty dishes or assisting residents with wiping their hands and faces. [s. 229. (4)]

3. During inspection, Inspector #577 observed a medication pass conducted by #S-112. The administration of medications was provided to two residents and hand hygiene was not performed before or after each task. The inspector inquired about the Home's policy on hand washing and medication administration and #S-112 reported that they should have washed their hands with sanitizer between residents. [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 that ensures that all staff participate in the implementation of the Infection Prevention and Control program, 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

During inspection, at 1135hrs, Inspector #196 observed #S-113 cutting the finger nails of Resident #081 in a common sitting room. This was within view of other residents and visitors to the home. [s. 3. (1) 8.]

WN #9: 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 failed to ensure that (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).

During inspection, Inspector #577 observed the headboard attached to a resident's bed frame to be very loose and easily movable. #S-110 was informed and reported they would notify maintenance. Inspector observed a resident's headboard attached to a bed frame to be very loose and easily movable and informed #S-114 who reported they would notify maintenance. [s. 15. (2)]

2. The licensee has failed to ensure that (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).

During inspection, Inspector #106 observed the striped upholstered chairs in one unit lounge area near the dining room, had multiple stains and ground in dirt on the arms, one of the striped chairs had stains on the front of the arms and the front of the seat. [s. 15. (2) (a)]

3. During inspection, Inspector #577 noted in a resident room, the washroom floor around the toilet was stained, the floor was sticky and an unlabelled blue urinal was on the washroom counter.

During inspection, in a resident room, the washroom floor was sticky, and the raised toilet seat was soiled with feces. During inspection, Inspector met with #S-108 and they reported there was sufficient housekeeping and cleaning supplies readily available to all staff at the home. [s. 15. (2) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. O. Reg. 79/10, s. 15 (1).

During inspection, Resident #042 was observed lying in bed with bilateral upper quarter side bed rails elevated. The current care plan was reviewed and included the intervention of "(they had) requested to have both 1/4 rails up for safety". According to #S-105, this resident had requested the quarter bilateral side bed rails to be elevated and they were not assessed as it was a resident request. [s. 15. (1) (a)]

2. The licensee failed to ensure that where bed rails are used, (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; O. Reg. 79/10, s. 15 (1).

During inspection, Inspector #577 observed a resident bed to have 2 half rails raised and an approximate gap of twenty centimeters between the headboard and the top of the mattress. Another bed, had one half rail and one quarter rail raised and an approximate gap of twelve centimeters between the head board and the top of the mattress.

During inspection, Inspector #577 conducted an interview with #S-108 and reported that the last audit was done one week previous and included side rail latching, entrapment zones and auditing mattresses for fit. According to #S-108, there is a plan to replace mattresses that do not fit, the previous audit was done within the year, no tools are used

to determine entrapment and a mattress assessment isn't done at the time of resident admission.

During inspection, Inspector #577 spoke with #S-105, and it was identified that an algorithm is used as a guide/tool to determine a resident's need for side rails on admission then it is done quarterly. They reported that the assessment results are not documented anywhere in the chart and bed rail usage are documented in the care plan.

During inspection, Inspector #577 met with #S-106 regarding assessments of residents related to bed rails and it was reported that nursing will assess on admission and gave the inspector the policy #LTC-K-10-ON regarding Side rails which stated "All residents using side rails will be assessed for the need for side rails and the associated risks with the utilization of side rails".

During inspection, Inspector #577 met with #S-108 and they provided a copy of their most recent mattress audit completed on September 25, 2014, and the audit completed May 2012 by an outside company. #S-108 confirmed to the inspector that these 2 mattresses were not the correct mattress for the beds in two particular rooms. [s. 15. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee failed to offered annual dental assessments and other preventative dental services, subject to payment being authorized by the resident/SDM if payment is required. O. Reg. 79/10, s. 34 (1).

During a stage one interview with the SDM for Resident #029, they indicated that the home does not offer an annual dental assessment or other preventive dental services. On October 1, 2014, #S-116, told Inspector #106 that annual dental screening is available in the home, but residents or families would have to request it. [s. 34. (1) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labelled within 48 hours of admission and of acquiring, in the case of new items; O. Reg. 79/10, s. 37 (1).

On four days of the inspection, on a unit, Inspector #577 noted a lingering odour of urine in a shared washroom in a resident room and observed an unlabelled blue urinal was placed on the bathroom counter. [s. 37. (1)]

2. The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items. O. Reg. 79/10, s.37 (1).

During inspection, Inspector #106 observed on a unit, 2 soiled unlabelled combs and 1 soiled unlabelled hair pick in a shower room and in a tub room , there was 1 soiled comb and an unlabelled brush that was soiled and full of hair. [s. 37. (1) (a)]

WN #13: 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 (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated. O. Reg. 79/10, r. 50.

The health care records for Resident #040 were reviewed on October 1, 2014, for information regarding altered skin integrity. The "Pressure Ulcer Risk Assessment - PURS"- dated in February 2014, was reviewed and identified that this resident was at "high risk" and recommended "additional preventative measures and skin care interventions as applicable". The current care plan identified daily dressing treatments. An interview was conducted with #S-117 on October 1, 2014, and they reported that the "Ongoing assessment - Treatment Observation Record (TOR)" is the tool used for weekly wound assessments and that a weekly assessment had not been completed for Resident #040 since August 27, 2014. [s. 50. (2) (b) (iv)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (6) The licensee shall ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, s. 71 (6).

Findings/Faits saillants :

1. The licensee has failed to ensure that a full breakfast is available to residents up to at least 8:30 a.m. and that the evening meal is not served before 5:00 p.m. O. Reg. 79/10, r. 71. (6)

On a specific day, at 1635hrs, Inspector #196 observed a unit dining room and noted that there were twenty-five residents seated at their respective tables. At 1645hrs, on a specific day, Resident #084 and #085 were observed to be assisted with dinner by a student at 1645hrs. #S-118 was asked what time dinner service was to start and they reported it starts at five.

On a specific day, at 1640hrs, approximately ten residents were observed to be eating their supper meal in a unit dining room. [s. 71. (6)]

2. On a specific day, at approximately 1710hrs, Inspector #106 entered a unit dining room. Almost all of the residents were finished their meals and staff were serving dessert. [s. 71. (6)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

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: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. 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 includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Dining service was observed during inspection, on a unit by Inspector #196. At 1231hrs, Resident #080 was provided with a piece of carrot cake by #S-100 and after placing it in front of the resident, this staff asked #S-101 if this resident could have a piece of cake as the dietary aid had provided it for this resident. #S-101 reported that Resident #080 was on a pureed diet and could not have a piece of cake. #S-100 was observed to remove the cake and provide a bowl of pudding instead.

The dietary reference sheet with print date of June 17, 2014, was reviewed and noted a "Puree" diet for Resident #080. The diet/fluid record as found posted on the wall in the servery identified this resident as on a "minced texture" diet.

The current care plan as found online in Point Click Care under the focus of Nutritional risk includes the intervention of "Provide High Calorie/High Protein diet- soft texture, regular fluids".

Staff were unaware of the texture of the diet this resident was to receive and the dietary reference sheet, the diet/fluid record and the care plan gave conflicting information. [s. 73. (1) 5.]

2. The Licensee failed to ensure that staff use proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

On October 2, 2014, at approximately 1710 hrs, Inspector #106 observed staff member #S-119 stand while feeding 2 different residents. [s. 73. (1) 10.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

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

On April 4, 2014, the home submitted a Critical Incident System (CIS) Report which indicated that a disease outbreak was declared on April 3, 2014. Inspector #106, reviewed the report and the home's case notes and no documentation was found to indicate the home immediately informed the Direction of the outbreak. [s. 107. (1)]

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

Issued on this 27th day of February, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196), DEBBIE WARPULA (577), MARGOT BURNS-PROUTY (106)
Inspection No. / No de l'inspection :	2014_246196_0017
Log No. / Registre no:	S-000353-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 27, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	PINEWOOD COURT 2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHERYL GRANT

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)

Linked to Existing Order / Lien vers ordre existant: 2013_211106_0027, CO #001;

Pursuant to / Aux termes de :

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

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall ensure that Resident #046's and Resident 029's plans of care are based on an interdisciplinary assessment, specifically in regards to their risk of falls and that all resident's plans of care are based on interdisciplinary assessments.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment with respect to the resident's health conditions, specifically risk of falls. O. Reg. 79/10, s. 26 (3).

A Critical Incident report was submitted to the Director in 2014 outlining a series of falls and subsequent injury requiring transfer to hospital for Resident #046.

On September 30, 2014, the health care records for Resident #046 was reviewed for information regarding falls and risk for falls. This resident was admitted to the home in 2014 and the initial "Falls Risk Assessment Tool - FRAT (2013)" completed on the day of admission, identified Resident #046 to be a medium risk for falls.

On September 30, 2014, an interview was conducted with #S-103 regarding the current care plan for Resident #046 related to risk for falls. It was confirmed to the inspector, that this resident has had several falls since admission to the home, but that the care plan remained unchanged. A total of six falls had occurred.

A falls risk assessment (FRAT) was completed after each of these falls and identified Resident #046 to be at high risk for falls. Despite being at a high risk for falls, and having six falls, no revisions were made to the plan of care.

Resident #046, as a result, sustained a serious injury after the latest fall.

(196)

2. In 2014, Resident #029 was admitted to the home. A Physiotherapy Assessment note was created on the day of admission, which indicated that the resident's overall risk of falls was high. A "Falls Risk Assessment Tool - FRAT (2013)" was also completed on the day of admission and it indicated that the resident scored 14 and was a medium risk for falls.

The "Resident Admission Assessment/Plan of Care" for Resident #029 was reviewed and other than the resident's name, room number, sex, date of birth and allergies, no other information was completed. On September 29, 2014, Inspector #106, asked the RAI Coordinator, where the initial plan of care is

documented, the RAI Coordinator indicated that staff were to document the initial plan of care on the "Resident Admission Assessment/Plan of Care" document and that is what is used as the resident's plan of care until the plan of care is completed after up to 21 days.

The falls section of the resident's plan of care was not completed until fifteen days after admission. For the first 15 days since admission, the resident did not have any interventions in their plan of care to prevent falls, even though the physiotherapy assessment indicated that they were a high risk to fall.

(106)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for Resident #026 and #080 that sets out, (c) clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. The most recent care plan document found on the computer and the Kardex for Resident #026 both indicated that the resident requires the physical assistance of 2 persons to transfer and the resident requires a transfer belt to transfer. The care plan document that was found in the care plan binder on September 26, 2014, indicated that the resident requires the assistance of one person to transfer and uses a walker to transfer.

Inspector #106 interviewed #S-102 and they reported that the resident requires the assistance of 2 staff members to transfer. The care plan document found in the care plan binder provides different direction to staff as compared to the care plan found on the computer and the Kardex.
(106)

2. Dining service was observed on September 22, 2014, on a specific unit by Inspector #196. At 1231hrs, Resident #080 was provided with a piece of carrot cake by #S-100 and after placing it in front of the resident, this staff asked #S-101 if this resident could have a piece of cake as the dietary aid had provided it for this resident. #S-101 reported that Resident #080 was on a pureed diet and could not have a piece of cake. #S-100 was observed to remove the cake and provide a bowl of pudding instead.

The dietary reference sheet with print date of June 17, 2014, was reviewed and it indicated a "Puree" diet for Resident #080. The diet/fluid record as found posted on the wall in the servery identified this resident as on a "minced texture" diet.

The current care plan as found online in Point Click Care under the focus of Nutritional risk includes the intervention of "Provide High Calorie/High Protein diet-soft texture, regular fluids".
Staff were unaware of the texture of the diet this resident was to receive and the dietary reference sheet, the diet/fluid record and the care plan gave conflicting information.
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 13, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Order / Ordre :

The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5)

A Critical Incident was submitted to the Director in 2014 outlining a fall with injury for which Resident #046 was taken to hospital and had resulted in a significant change to their health status. The resident had a series of falls over a two day period and it was documented in the progress notes that the Substitute Decision Maker (SDM) was informed of each fall occurrence. The progress notes documented, outlined an assessment of the resident, which included a loss of consciousness after falling backwards and hitting the back of their head. According to an interview with the SDM, they reported that they were not informed that after this particular fall, Resident #046 had become unconscious for a period of time.

An interview was conducted with #S-106 and it was confirmed that the Substitute Decision Maker (SDM) was not made aware of the Resident #046's

loss of consciousness after the fall. The SDM was notified of the loss of consciousness by #S-107 the following morning, when their family member was sent to hospital for assessment for treatment.
(196)

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

On September 29, 2014, Inspector #577 met with Resident #003 and it was reported they had told #S-105 that they did not want #S-104 involved in their care. On September 29, 2014, Inspector #577 spoke to #S-104 and they reported Resident #003 had requested no male staff since last week and they were complying with their wishes. Inspector #577 reviewed the resident's care plan and noted that the resident's request was not included in the plan of care.

On September 30, 2014, the inspector spoke with #S-105 concerning the complaint from Resident #003 and it was confirmed that this resident had requested that #S-104 not be involved in their care and this was then reported to the RN working that shift. On September 30, 2014, Inspector #577 reviewed the progress note as documented by #S-105, which identified that this resident requested not to have this staff provide care for them.

On October 1, 2014, the inspector interviewed #S-106 and informed them of Resident #003's request not to have this PSW involved in their care. According to #S-106, they had become aware of the request the day prior and that this information should have been documented in the care plan. On October 2, 2014, Inspector #577 reviewed the resident's care plan and noted that the resident's request was not included in the plan of care. (577)

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

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 27th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

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

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