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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Nov 10, 2016;	2016_512196_0012 (A1)	036355-15, 000648-16, 005640-16, 022238-16, 022240-16, 022242-16	Follow up

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Compliance Order #005 has been extended to November 30, 2016, upon request of the Licensee.

Issued on this 10 day of November 2016 (A1)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Nov 10, 2016;	2016_512196_0012 (A1)	036355-15, 000648-16, 005640-16, 022238-16, 022240-16, 022242-16	Follow up

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) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 15, 16, 17, 18, 19 and 22, 2016.

The following intakes were inspected: one related to medication administration; one related to plan of care; one related to abuse/neglect of residents, bed rails, sanitary furnishings/equipment and the availability of fall prevention equipment; two related to the hot water system and one related to bathing.

During the course of the inspection, the Inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, observed the provision of care and services to residents, reviewed various home policies and procedures, and reviewed several resident health care records.

This Follow Up inspection was conducted concurrently with Complaint inspection #2016_512196_0013 and Critical Incident System inspection #2016_512196_0014.

Non-compliance found in concurrent Critical Incident System inspection #2016_512196_0014, regarding LTCHA 2007, s.19., has been issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Assessment Instrument (RAI) Coordinator, Environmental Services Manager (ESM), Pharmacist, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Falls Prevention

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Safe and Secure Home

Skin and Wound Care

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

- **8 WN(s)**
- **2 VPC(s)**
- **5 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
O.Reg 79/10 s. 15. (1)	CO #002	2015_246196_0016	196
LTCHA, 2007 s. 15. (2)	CO #003	2015_246196_0016	196
LTCHA, 2007 s. 15. (2)	CO #001	2016_333577_0007	625
O.Reg 79/10 s. 49. (3)	CO #004	2015_246196_0016	196

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection 2015_401616_0017. The licensee was to do the following by December 9, 2015:

a) Perform an audit of all residents of the home that required oral care assistance by staff to verify that the care provided was as specified in the plan of care. Based on the results of this audit, the licensee would implement interventions to meet the dental care needs of identified residents.
b) Specifically ensure that resident #001 received oral care based on assessed needs as well as ensure the plan of care related to oral care was up to date to reflect the current needs of resident #001.
c) Perform an audit of all residents of the home that required wound care interventions to verify that the skin and wound care provided was as specified in the plan of care. Based on the results of this audit, the licensee would implement interventions to meet the skin and wound care needs of identified residents.
d) Specifically ensure that resident #001 and #002 received skin and wound care as specified in the plans of care and ensure the plans of care related to skin and wound care was up to date to reflect the current needs of resident #001 and #002.
e) Perform an audit of all residents of the home that required bed alarms to ensure that bed alarms were in place and functional as specified in the plan of care. Furthermore, the licensee was to ensure there was a process for staff to follow if problems with bed alarm equipment or supply was identified with a plan to prevent or mitigate risks for falls.
f) Specifically ensure that the staff provide bed alarm interventions for residents #012, #013, #016 as specified in the plans of care. This review and update of each resident's plan of care must be completed by December 9, 2015.

During the inspection, a review by Inspector #625 of resident #004's care plan, identified that the resident was at risk for falls and required a falls prevention device while seated and while in bed, with the goal of reducing the number of falls the resident experienced.

On a particular day, Inspector #625 observed resident #004 laying in bed with a falls prevention device in place. The Inspector was not able to assess the falls prevention device further at that time as the resident was asleep. On another day, Inspector observed resident #004 seated in their wheelchair with a falls prevention

device that was previously on the resident's bed, was attached to their wheelchair. Inspector #625 detached the falls prevention device apparatus and noted that the alarm did not sound. The battery was held in place with a piece of medical tape, and the battery contacts were not aligned properly with the alarm unit to power the alarm. Inspector waited with resident #004 for five minutes, until staff approached the area.

During an interview with Inspector #625 about the malfunctioning falls prevention device, RPN #109 stated that the resident used the falls prevention device when in bed. When the Inspector identified that the resident's current care plan indicated that the falls prevention device was used when the resident was in bed and in the wheelchair, the RPN stated that they would replace the falls prevention device or get a proper cover for it, so that it functioned as required.

During an interview with Inspector #625 on August 18, 2016, the Director of Care (DOC) stated that falls prevention equipment were available to staff 24 hours per day. The DOC stated that the RN on duty could access the equipment at any time, to ensure that functional equipment was used for residents in the home, according to their care plans. [s. 6. (7)]

2. A review by Inspector #625 of resident #009's health care record identified progress note entries related to lack of a falls prevention device in use, despite being required. On a specific day, a progress note identified that the resident's falls prevention device was not working properly, was placed at the nursing station, the RN was aware, and a message had been left for the Environmental Services Manager (ESM). A note entered at 1330 hours indicated that the falls prevention device had been replaced. At 2243hrs, a note indicated that the new falls prevention device was not working as required, that the staff had not been able to fix the falls prevention device, that the device had been unplugged, and that frequent checks of the resident were required. On another day, at 0920 hours, the DOC documented that the falls prevention device was checked and found to be not working, and was removed and replaced.

A review by Inspector #625 of resident #009's current care plan identified that the resident was at risk for falls and required a falls prevention device, with the goal of remaining free from falls.

During an interview with Inspector #625, the DOC stated that falls prevention equipment were available to staff 24 hours per day. The DOC stated that the RN

on duty could access the equipment at any time, to ensure that functional equipment was used for residents in the home, according to their care plans. The DOC acknowledged that staff should have replaced the falls prevention device immediately, and should not have left a message for the ESM who was on vacation that week, or waited for the DOC to replace the falls prevention device upon their return from vacation. The DOC stated that staff had not provided care to resident #009, regarding their use of a falls prevention device, as set out in their care plan. [s. 6. (7)]

3. The licensee has failed to ensure that the following are documented: The provision of the care set out in the plan of care.

During the inspection, the homes' "Daily Infection Control Surveillance Form" was reviewed by Inspector #196. Resident #006 was identified on the form as having a specific medical condition.

The health care records for resident #006 were reviewed by Inspector #196. The physician's orders with a specific date, included an order for a laboratory test and a specific type of medical monitoring daily for seven days, then routine medical monitoring. The order was processed on the same date it was ordered and included written documentation that it was put on the TAR (treatment administration record). In addition, the note from the physician indicated a question of a particular medical condition that required monitoring. The online charting in Point Click Care (PCC) did not include documentation of the ordered specific type of medical monitoring on five out of seven days.

During the inspection, Inspector #196 conducted an interview with the DOC regarding the physician's order for medical monitoring for resident #006 for a period of seven days. The DOC reviewed the progress notes and the medical monitoring record in PCC and confirmed to the Inspector that they had not been documented as ordered. The DOC added that the daily task of medical monitoring was put into the TAR and was to be done for a seven day period. In addition, the DOC confirmed that there was no evidence that the specific type of medical monitoring was done, although the registered staff had indicated on the TAR that the task was completed but there was no documentation in PCC. According to the DOC, there was no evidence that the specific type of medical monitoring was done as ordered by the physician as there was no other place for the staff to record the results. [s. 6. (9) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The home has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #003 issued during inspection #2016_333577_0007. The licensee was ordered to ensure that each resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, specifically in regards to all residents on a specific unit. This was to be done by June 28, 2016.

During the inspection, a review by Inspector #625 of the home's policy "Bathing and Showering – LTC-H-40" last revised March 2016, identified that residents would be offered a tub bath or shower at least two times weekly.

Inspector #625 reviewed the bath schedule for one of the home's units and it indicated that resident #006 was scheduled to have a bath on two specific evenings. A review of resident #006's health care record identified no documentation related to the resident's scheduled bath on one specific evening and the records identified that one shower was provided during that particular week in the summer of 2016.

Inspector #625 reviewed the bath schedule for another one of the home's units and it indicated that resident #022 was scheduled to have a bath on two specific evenings. A review of resident #022's health care record identified no documentation present related to the resident's scheduled bath on one specific evening and the records identified that one bath was provided during that particular week in the summer of 2016.

Inspector #625 reviewed the bath schedule for another one of the home's units and it indicated that resident #023 was scheduled to have a bath on two specific mornings. A review of resident #023's health care record identified no documentation related to the resident's scheduled bath on one of the specific mornings and the records identified that one bath was provided during that particular week in the summer of 2016.

Inspector #625 reviewed the bath schedule for another one of the home's units and it indicated that resident #024 was scheduled to have a bath on two specific mornings. A review of resident #024's health care record identified no documentation related to the resident scheduled baths and the records identified that no bathing was provided to resident #024, during that particular week in the summer of 2016.

During an interview with Inspector #625, PSW #110 stated that they had worked the evening of one of the shifts in which residents were not bathed and that the unit had been working short one personal support worker and, consequently, no baths were provided to residents that evening.

During an interview with Inspector #625, RPN #109 stated that they had worked the day shift of one of the shifts in which residents were not bathed and that the unit had been working short one personal support worker at that time and, consequently, no baths or showers had not been provided to resident #022, #023 and #024 that day.

During an interview with Inspector #625, the DOC #102 acknowledged that baths had been scheduled for residents #006 and #009 on a specific evening, but had not been documented in either resident's health care record. The DOC reviewed one of the units personal support worker huddle sheet which had a notation that staff worked with one less personal support worker and could not complete scheduled baths. The DOC said that the entry should have triggered the Registered Nurse on duty to call in extra staff to make up the baths, but that it did not occur. During the same interview, the DOC acknowledged that baths had been scheduled for residents #022, #023 and #024 on a specific morning, but had not been documented in any of the residents' health care records. The DOC reviewed another units personal support worker huddle sheet for another date and noted that no missed baths were recorded on the sheet, and stated that the Registered Nurse had not been triggered to call in staff to make up the baths for that reason. [s. 33. (1)]

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. 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 protect residents from abuse by anyone and that

residents were not neglected by the licensee or staff.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection 2015_246196_0016. The licensee was ordered to do the following by March 7, 2016:

a/ ensure that staff monitor and record symptoms of infections in residents on every shift and take appropriate action as necessary.
b/ ensure that the care set outlined in the plan of care was provided to residents as specified in their plans, specifically that physician's orders were processed and implemented
c/ ensure a system was initiated that was to be used by registered staff that would identify outstanding resident items requiring followup.

During the inspection, the homes' "Daily Infection Control Surveillance Form" was reviewed by Inspector #196. Resident #009 was identified on the form as having a specific medical condition and the onset date was not indicated. In addition, treatment for the specific medical condition was identified.

The health care records for resident #009 were reviewed by Inspector #196. The progress notes on a particular day identified an assessment of an area on the resident's body. On another day, a note identified an assessment of the same area of the resident's body. An additional note, identified a related concern. One day later, an assessment of the area of the resident's body was conducted on all three shifts and documented accordingly. The following day, the DOC documented an assessment of the area of the resident's body and noted that the physician was informed and that the MD (Medical Doctor) would assess the area in two days time and that staff were to monitor the medical condition. A note five days later indicated the start treatment for the medical condition and there was no documentation of the purpose of the treatment or an assessment of the medical condition was recorded. On that same day, a measure of one of the resident's vital signs documented. No further assessments of the area of the resident's body were documented or located until seven days later when the MD assessed the area of the resident's body.

During the inspection, Inspector #196 conducted an interview with the DOC. The DOC reported that the registered staff should have checked and assessed the resident in relation to the medical condition every shift and documented a progress note of the assessment. Inspector #196 and the DOC reviewed the progress notes

for resident #009 and the DOC confirmed to the Inspector that the monitoring of the medical condition had not been documented every shift. There were a total of 35, eight hour shifts, in which an assessment of the medical condition was not recorded, in the progress notes from the date of onset through to the last assessment.

Inspector #196 reviewed the licensee's policy titled Review of "Infection Surveillance - Ontario - IPC-J-10-ON" revised May 2014. The policy identified that the unit Nurse/designate will be responsible for documenting signs and symptoms of infection in the Resident's Interdisciplinary Progress Notes. [s. 19.]

2. During the inspection, the homes' "Daily Infection Control Surveillance Form" was reviewed by Inspector #196. Resident #008 was identified on the form as having a specific medical condition and the onset date and treatment initiation date was not noted.

The health care records for resident #008 were reviewed by Inspector #196. The progress notes on a specific date indicated the resident's development of a specific medical condition and noted that the RN would be informed and a note for the MD (Medical Doctor) was made.

Five days later, a note indicated that treatment was started. Eleven days later, there was an assessment of the specific medical condition and it identified that the condition was getting worse. The following day, an assessment of the medical condition was done by the RN and noted that the MD was to be informed the following day shift.

During the inspection, Inspector #196 conducted an interview with the DOC. The DOC reported that the registered staff should check and assess the medical condition every shift and document a progress note of the assessment. Inspector #196 and the DOC reviewed the progress notes for resident #008 and the DOC confirmed to the Inspector that the monitoring of the medical condition had not been documented every shift. There were a total of 44, eight hour shifts, in which an assessment of the medical condition was not recorded in the progress notes. [s. 19. (1)]

3. The licensee has failed to ensure that residents were protected from abuse by anyone and were not neglected by the licensee or staff.

Three Critical Incident System (CIS) reports were submitted to the Director in the spring of 2016 for staff to resident abuse and neglect. All three incidents identified PSW #124 as the alleged abuser.

The first CIS report was for an incident of staff to resident verbal abuse which had occurred on a specific day.

According to the report, PSW #123 had overheard PSW #124 yelling at resident #001. In addition, the report indicated that resident #001 was observed to be upset with what had been told to them.

The second CIS report was for an incident of staff to resident abuse/neglect which had occurred on a specific day, six days after the first incident.

According to the report, PSW #124 had told resident #012 that they should be wearing a specific type of continence product and then did not provide assistance to the washroom when the resident had asked. The report also noted that PSW #124 did provide a bed pan to the resident a couple of hours after first being asked for washroom assistance although the resident was able to get to the washroom if assisted.

The third CIS report was for an incident of staff to resident verbal abuse which had occurred on a specific day, six days after the first incident.

According to the report, resident #013 had rang the call bell for assistance and PSW #124 responded by belittling the resident.

Inspector #196 conducted an interview with the DOC regarding the home's investigation into the abuse incidents. They confirmed to Inspector #196, that all three occurrences had not been immediately reported to the Director. In addition, they confirmed that PSW #124 continued to work after the first incident of verbal abuse on a specific day, after the second incident of neglect/abuse and third incident of verbal abuse which both occurred six days later.

The employee records for PSW #124 were reviewed by Inspector #196. A letter identified all three identified incidents and subsequent termination from the home. [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that hot water boilers and hot water holding tanks were serviced at least annually, and that documentation was kept of the service.

Inspector reviewed a Service Order from the spring of 2016, reflecting the home's quarterly preventative maintenance services on the hot water boilers provided by an outside company. The record indicated that certain components of the hot water boiler were checked and preventative maintenance was completed. The record contained no reference to the hot water holding tanks, or any service completed on the tanks.

During an interview with Inspector #625, the Environmental Services Manager (ESM) #101 stated that there was no specific preventative maintenance or service completed on the hot water holding tanks, and that the home did not have any documentation of service to the hot water holding tanks. [s. 90. (2) (f)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the water that served all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius, and was controlled by a device, inaccessible to residents, that regulated the temperature.

Inspector #625 reviewed the home's policy "Daily Maintenance Audit – ESP-B-05" dated September 2004, which indicated that the Daily Maintenance Audit Form was to be completed daily and the domestic hot water for resident care areas was to be between 40 and 49 degrees Celsius.

A review by Inspector #625 of the home's Daily Maintenance Audit for a particular month identified that the hot water source was recorded as exceeding 49 degrees Celsius on nine days out of the month or 29 per cent of the time.

A review by Inspector #625 of the Air & Water Temperature Chart for a particular month identified that water temperature readings obtained in resident care areas exceeded 49 degrees Celsius as follows:

On one specific unit, there were three days in which the temperature exceeded 49 degrees Celcius. On another specific unit, there were four days in which the temperature exceeded 49 degrees Celcius. On another unit there were two days in which the temperature exceeded 49 degrees Celcius and the last unit had seven days in which the temperature exceeded 49 degrees Celcius.

During an interview with Inspector #625, the ESM confirmed that the hot water supply to temperature was to be maintained between 40 and 49 degrees Celsius,

but had not been. [s. 90. (2) (g)]

3. The licensee has failed to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #002 issued during inspection #2016_333577_0007. The licensee was ordered to ensure that procedures were developed and implemented to ensure that, if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water. This was to be done by June 28, 2016.

Also the home was to ensure that the following monitoring mechanisms were completed and recorded:
1) The Daily Maintenance Audit
2) The Hot Water Temperature Recording daily from different locations within the home
3) The Bath/Shower Water Temperature logs for each home unit, measured and recorded for every resident bath/shower

Inspector #625 reviewed “Air & Water Temperature Charts” dated for a particular month for all four resident home areas in the home. The document template contained locations for staff to obtain water temperature readings from during each shift. Locations listed on the night shift included the Wellness Center, Soiled Utility Room, Medication Room, Clean Utility Room and Housekeeping Closet.

During an interview with Inspector #625, the ESM stated that the locations from which staff were required to obtain water readings every shift, as listed on the “Air & Water Temperature Chart” used by the home, contained location where residents did not have access to hot water.

During an interview with Inspector #625, the DOC stated that residents did not have access to the all of the locations where the water temperature readings had been taken including the Wellness Center, Soiled Utility Room, Clean Utility Room and Housekeeping Closet.

(2) A review by Inspector #625 of the home’s policy “Bathing and Showering –

LTC-H-40" last revised March 2016, identified that three water temperature checks were to be completed prior to providing a resident with a tub bath. The first check involved an integrated tub thermometer (if available) or a hand-held thermometer taken while the water was running, the second check involved a hand-held thermometer taken in the water until the temperature reading was steady, and the third check involved immersing the staff member's forearm in the water for at least five seconds.

The policy also identified three checks were required prior to giving a resident a shower. The first check involved checking the water temperature using the staff person's forearm while the shower was running, the second check involved immersing the staff person's forearm in the water stream for at least five seconds immediately prior to the resident entering the shower, and the third check involved placing either the resident's forearm or staff person's forearm in the water stream, again, for at least five seconds before the resident enters the shower.

On a particular day during the inspection, Inspector #625 observed two signs posted in one of the units Spa/Bathing Room. One was titled "Have You Checked Your Shower/Tub Temperatures?" and reminded staff to perform and record three water temperature checks prior to each resident bath or shower as per the home's policy. The second sign was titled "Bath/Shower Water Temperatures" and stated that water temperatures were to be taken before each resident bath using three checks and provided details on how to complete each check.

Inspector #625 then reviewed the "Bath/Shower Water Temperature Log" found in another Spa/Bathing Room. The log was incomplete as it contained 12 entries taken on seven different dates. Ten out of the 11 entries, or 91 per cent of the entries, were incomplete and were missing specific temperature readings and/or checks.

Inspector #625 also reviewed the "Bath/Shower Water Temperature Log" found in another Spa/Bathing Room and Shower/Washroom. The log from the Spa/Bathing room was incomplete as it contained 32 entries taken on 14 different dates. Eight out of 14 , or 57 per cent, of entries required to be taken prior to the first bath of the day were not completed correctly, as all eight did not have the temperature from the integrated tub thermometer listed, including one entry which also did not have a temperature from the hand-held thermometer listed, as the log indicated was required. The log from the Shower/Washroom contained 34 entries, all of which were completed incorrectly as all did not have three hand/arm checks combined

completed, as the log indicated was required.

During an interview with Inspector #625 on August 18, 2016, the DOC acknowledged that both of the units “Bath/Shower Water Temperature Logs” were not complete and/or were not completed correctly.

(3) In addition to the “Bath/Shower Water Temperature Logs” being incomplete, or completed incorrectly, for resident baths and showers, some resident baths and showers contained no documentation that the first checks were completed, when a bath or shower had been provided.

Inspector #625 reviewed health care records for resident #006 which indicated that the resident had a shower on a specific day. A review by the Inspector of the “Bath/Shower Water Temperature Log” for that time period identified that no water temperature checks for resident #006’s shower had been recorded.

Inspector #625 reviewed health care records for resident #009 which indicated that the resident had a shower on a specific day. A review by the Inspector of the “Bath/Shower Water Temperature Log” for that time period identified that no water temperature checks for resident #009’s shower had been recorded.

Inspector #625 reviewed health care records for resident #020 which indicated that the resident had a bath on a specific day. A review by the Inspector of the “Bath/Shower Water Temperature Log” for that time period identified that no water temperature checks for resident #020’s bath had been recorded.

During an interview with Inspector #625, the DOC acknowledged that resident #006 had a shower on a specific day, resident #009 had a shower on a specific day, and resident #020 had a bath on a specific day, but that the corresponding water temperature checks had not been recorded on the “Bath/Shower Water Temperature Log”. [s. 90. (2) (k)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures procedures are developed and implemented to ensure that hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service and that the temperature of the water that serves all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection #2015_433625_0002. The licensee was do the following by December 4, 2015:

(a) Ensure that drugs were administered to resident #001, and every other resident living in the home, in accordance with the directions for use specified by the prescriber including, but not limited to, the correct number of doses, the correct administration times and the correct instructions for use; and
(b) Ensure all registered nursing staff were familiar with and adhered to the

licensee's policies governing the processing of medication orders and administration of medications.

The licensee has failed to comply with the order, specifically related to the same resident identified in Critical Incident System Inspection report #2015_433625_0002, Compliance Order #001.

During the inspection, Inspector #625 reviewed resident #001's health care record, which included a "Physician's Digiorder" from a particular day in the winter of 2015. The order had discontinued a specific medication. Resident #001's electronic Medication Administration Record (eMAR) for one particular month in the summer of 2016 listed the previously discontinued medication. The resident's health care record did not contain a current order for this medication despite the entry listed on the current eMAR and signed for as administered on four separate dates in the summer of 2016.

During an interview with Inspector #625, RPN #109 reviewed resident #001's health care record but was not able to locate a current physician's order for the specific medication as was listed on the eMAR.

A review by Inspector #625 of the home's policy "Medication Administration – LTC-F-20" revised January 2016, identified that the medication administration process was to comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

A review by Inspector #625 of the home's pharmacy provider's "Guide to Processing eMAR Orders" identified that a nurse was to enter into eMAR when an order was discontinued orders or placed on hold. A second nurse was to ensure the accuracy of the order entered into the eMAR by the first nurse or pharmacy.

During an interview with Inspector #625, the DOC stated that the entry for this specific medication listed on resident #001's eMAR for the month in which the medication was given four times, was not currently ordered by the physician, and it had been discontinued on a specific date in the winter of 2015. The DOC stated that staff had not followed the pharmacy provider's policy as the first nurse who processed the order had not discontinued the order on the eMAR, and the second nurse who conducted a second check of the order had not verified the accuracy of the processing of the order on the eMAR. [s. 131. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

During the inspection, Inspector #625 observed a door to one of the Soiled Utility Rooms to be propped open and the area to be unsupervised by staff. A sign was present on the door that indicated staff were to ensure the door was kept locked.

During an interview with RPN #112 about the door, they stated that the door was to remain closed and locked, as per the sign on the door, but that staff had failed to follow the direction provided regarding the door.

On another day during the inspection, Inspectors #196 and #625 observed the door to the DOC's office to be opened and unsupervised from 1738-1745hrs. At 1745hrs, the DOC returned to the office from the Hummingbird resident home area and, when asked, stated that residents were not permitted in the office when the DOC was not present to supervise them, and that the door to the office had not been closed and locked, but should have been. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they were not being supervised by staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: 11. Every resident has the right to, iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007.

On a day during the inspection, from 0855 to 0857hrs, Inspector #625 observed the medication cart located outside of the dining room on one of the home's units. The cart was unattended and had an unlocked computer monitor that displayed personal health information (PHI) for resident #025, including resident #025's name, medications and vital signs. RPN #111 returned to the cart at 0857hrs and stated that they were new and did not know how to lock the monitor to secure the resident information listed on the monitor, but would contact the Registered Nurse on duty for direction.

The same day, at 0909hrs, Inspector #625 observed PHI for resident #026 visible on the same medication cart, in the same location. PHI visible included resident #026's name, medications, monitoring related to a medical condition, and vital signs. RPN #111 had left the cart unattended and, when the RPN returned to the cart, they stated that the Registered Nurse had not been able to instruct them on how to lock the monitor when they stepped away.

During an interview with Inspector #625, the DOC stated that staff must lock the medication cart monitors when they step away from the medication carts, that RPN #111 should have been shown how to do that during their orientation shifts, and that all staff should lock the monitors to protect resident PHI when stepping away from medication carts. [s. 3. (1) 11. iv.]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During the inspection, Inspector #196 observed RN (Temp) #113 to have a name tag identifying them as a Registered Nurse. At that time, RN (Temp) #113 stated to the Inspector that they were working with the DOC that day as they were employed in a new graduate initiative program, had not yet written the NCLEX-RN exam, and that there was no other registered nurse in the home.

During an interview with Inspector #625, RN (Temp) #113 stated that they had been scheduled to work in the home with the DOC throughout that week as there was no other RN in the home.

Inspector #625 observed RN (Temp) #113 to work under the supervision of the DOC, with no other RN in the home, on the day shifts on two particular days during the inspection.

A review by Inspector #625 of information provided the College of Nurses of Ontario website identified that members of the Temporary Class must identify themselves using the titles of “Registered Nurse (Temporary)” or “RN (Temp)”, in the case of members registered as registered nurses. The College of Nurses of Ontario also outlined terms, conditions and limitations to the Temporary Class member including that the RN (Temp) must be monitored and directed by a nurse in the General or Extended Class; must not perform a controlled or authorized act unless the act is ordered under clause 5 (1) (b) of the Nursing Act, 1991, or by an RN in the General Class; must not supervise, monitor or direct the performance of a controlled or authorized act or the practice of another nurse; must not accept the

delegation of a controlled or authorized act from another nurse or anyone else; and must not delegate to another nurse or anyone else the authority to perform a controlled or authorized act.

During an interview with Inspector #196, the Executive Director (ED) stated that the graduate initiate position followed guidelines set out by the Ministry of Health and Long-Term Care related to the program, and was supernumerary in nature.

Inspector #196 conducted an interview with the DOC. They reported that they did not have a RN working that day as the RN that was scheduled had called in sick and no other RN staff were available to replace the shift because of vacation time. The DOC also stated that a graduate nurse, RN (Temp) #113, was also working that day, but that there was no other RN on site. [s. 8. (3)]

Issued on this 10 day of November 2016 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LAUREN TENHUNEN (196) - (A1)
Inspection No. / No de l'inspection :	2016_512196_0012 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / Registre no. :	036355-15, 000648-16, 005640-16, 022238-16, 022240-16, 022242-16 (A1)
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 10, 2016;(A1)
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: 2015_401616_0017, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to ensure that the care set out in the plan of care is provided to all residents as specified in their plans of care.

The licensee is specifically ordered to:
a/ Ensure the care plan for resident #004 is current and that care is provided to
the resident as specified, related to the use of a falls prevention device.
b/ Ensure the care plan for resident #009 is current and that care is provided to
the resident as specified, related to the use of a falls prevention device.

Grounds / Motifs :

1. A review by Inspector #625 of resident #009's health care record identified progress note entries related to lack of a falls prevention device in use, despite being required. On a specific day, at 0254hrs (hours), a progress note identified that the resident's falls prevention device was not working properly and was placed at the nursing station, the RN was aware, and a message had been left for the Environmental Services Manager (ESM). A note entered at 1330 hours indicated that the falls prevention device had been replaced. At 2243hrs, a note indicated that the

new falls prevention device was not working as required, that the staff had not been able to fix the a falls prevention device, that the falls prevention device had been unplugged, and that frequent checks of the resident were required. On another day, at 0920 hours, the DOC documented that the falls prevention device was checked and found to be not working, and was removed and replaced.

A review by Inspector #625 of resident #009's current care plan identified that the resident was at risk for falls and required a a falls prevention device with the goal of remaining free from falls.

During an interview with Inspector #625, the DOC stated that falls prevention equipment were available to staff 24 hours per day. The DOC stated that the RN on duty could access the equipment at any time, to ensure that functional equipment was used for residents in the home, according to their care plans. The DOC acknowledged that staff should have replaced the falls prevention device immediately, and should not have left a message for the ESM who was on vacation that week, or waited for the DOC to replace the falls prevention device upon their return from vacation. The DOC stated that staff had not provided care to resident #009, regarding their use of falls prevention device, as set out in their care plan.

Non-compliance pursuant to LTCHA 2007, c.8, s.6.(7) had previously been issued under inspection report #2015_401616_0017, which included a compliance order served November 20, 2015, inspection report #2015_246196_0016, which included a voluntary plan of correction in November 2015, and under inspection report #2015_269597_0004, which included a compliance order served July 12, 2015.

The decision to re-issue this compliance order was based upon the scope which was a pattern of two residents, the severity which indicated minimal harm or potential for actual harm and the compliance history, which despite previous non-compliance has continued in this area of the legislation.

(625)

2. A review by Inspector #625 of resident #009's health care record identified progress note entries related to lack of a falls prevention device in use, despite being

required. On a specific day, at 0254hrs (hours), a progress note identified that the resident's falls prevention device was not working properly and was placed at the nursing station, the RN was aware, and a message had been left for the Environmental Services Manager (ESM). A note entered at 1330 hours indicated that the falls prevention device had been replaced. At 2243hrs, a note indicated that the new falls prevention device was not working as required, that the staff had not been able to fix the a falls prevention device, that the falls prevention device had been unplugged, and that frequent checks of the resident were required. On another day, at 0920 hours, the DOC documented that the falls prevention device was checked and found to be not working, and was removed and replaced.

A review by Inspector #625 of resident #009's current care plan identified that the resident was at risk for falls and required a a falls prevention device with the goal of remaining free from falls.

During an interview with Inspector #625, the DOC stated that falls prevention equipment were available to staff 24 hours per day. The DOC stated that the RN on duty could access the equipment at any time, to ensure that functional equipment was used for residents in the home, according to their care plans. The DOC acknowledged that staff should have replaced the falls prevention device immediately, and should not have left a message for the ESM who was on vacation that week, or waited for the DOC to replace the falls prevention device upon their return from vacation. The DOC stated that staff had not provided care to resident #009, regarding their use of falls prevention device, as set out in their care plan.

Non-compliance pursuant to LTCHA 2007, c.8, s.6.(7) had previously been issued under inspection report #2015_401616_0017, which included a compliance order served November 20, 2015, inspection report #2015_246196_0016, which included a voluntary plan of correction in November 2015, and under inspection report #2015_269597_0004, which included a compliance order served July 12, 2015.

The decision to re-issue this compliance order was based upon the scope which was a pattern of two residents, the severity which indicated minimal harm or potential for actual harm and the compliance history, which despite previous non-compliance has continued in this area of the legislation.

(625)

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

Nov 18, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0007, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall:

a/ ensure that all residents of the home are bathed, at a minimum, twice a week, as per their plans of care.
b/ develop a process that will ensure any residents whose baths are missed will be rescheduled and care will be provided as per their plans of care.

Grounds / Motifs :

1. The home has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #003 issued during inspection #2016_333577_0007. The licensee was ordered to ensure that each resident was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, specifically in regards to all residents on a specific unit. This was to be done by June 28, 2016.

A review by Inspector #625 of the home's policy "Bathing and Showering – LTC-H-40" last revised March 2016, identified that residents would be offered a tub bath or shower at least two times weekly.

Inspector #625 reviewed the bath schedule for one of the home's units and it indicated that resident #006 was scheduled to have a bath on two specific evenings. A review of resident #006's health care record identified no documentation related to the resident's scheduled bath on one specific evening and the records identified one shower was provided during that particular week in the summer of 2016.

Inspector #625 reviewed the bath schedule for another of the home's units and it indicated that resident #022 was scheduled to have a bath on two specific mornings. A review of resident #022's health care record identified no documentation present related to the resident's scheduled bath on one of the specific mornings and the records identified one bath was provided during that particular week in the summer of 2016.

Inspector #625 reviewed the bath schedule for another of the home's units and it indicated that resident #023 was scheduled to have a bath on two specific mornings. A review of resident #023's health care record identified no documentation present related to the resident's scheduled bath on one specific morning and the records identified one bath was provided during that particular week in the summer of 2016.

Inspector #625 reviewed the bath schedule for another of the home's units and it indicated that resident #024 was scheduled to have a bath on two specific mornings. A review of resident #024's health care record identified no documentation present

related to resident #024’s scheduled bath on one specific morning and the records identified that no bathing was provided during that particular week in the summer of 2016.

During an interview with Inspector #625, PSW #110 stated that they had worked the evening of one of those shifts in which residents were not bathed and that the unit had been working short one personal support worker and, consequently, no baths were provided to residents that evening.

During an interview with Inspector #625, RPN #109 stated that they had worked the day shift of one of those shifts in which residents were not bathed and that the unit had been working short one personal support worker at that time and, consequently, no baths or showers had not been provided to resident #022, #023 and #024 that day.

During an interview with Inspector #625, the DOC #102 acknowledged that baths had been scheduled for residents #006 and #009 on a specific evening, but had not been documented in either resident’s health care record. The DOC reviewed one of the unit's personal support worker huddle sheet which had a notation that staff worked with one less personal support worker and could not complete scheduled baths. The DOC said that the entry should have triggered the Registered Nurse on duty to call in extra staff to make up the baths, but that it did not occur. During the same interview, the DOC acknowledged that baths had been scheduled for residents #022, #023 and #024 on a specific morning, but had not been documented in any of the residents’ health care records. The DOC reviewed another unit's personal support worker huddle sheet noted that no missed baths were recorded on the sheet, and stated that the Registered Nurse had not been triggered to call in staff to make up the baths for that reason.

Non-compliance pursuant to O.Reg.79/10, r.33.(1) had previously been issued under inspection report #2016_333577_0007, which included a compliance order served June 14, 2016.

The decision to re-issue this compliance order was based on the scope of the issue, which was a pattern of residents, the severity which identified that minimal harm or potential for risk of harm occurred; and the compliance history, which despite previous non-compliance has continued in this area of the legislation.

(625)

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

Nov 18, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_246196_0016, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. Duty to protect

Order / Ordre :

The licensee shall ensure that all residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to protect residents from abuse by anyone and that residents were not neglected by the licensee or staff.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection 2015_246196_0016. The licensee was ordered to do the following by March 7, 2016:

a/ ensure that staff monitor and record symptoms of infections in residents on every shift and take appropriate action as necessary.
b/ ensure that the care set outlined in the plan of care was provided to residents as specified in their plans, specifically that physician's orders were processed and implemented.
c/ ensure a system was initiated that was to be used by registered staff that would identify outstanding resident items requiring followup.

During the inspection, the homes' "Daily Infection Control Surveillance Form" was reviewed by Inspector #196. Resident #009 was identified on the form as having a specific medical condition and the onset date was not indicated. In addition, treatment for the specific medical condition was identified.

The health care records for resident #009 were reviewed by Inspector #196. The progress notes on a particular day identified an assessment of an area on the resident's body. On another day, a note identified an assessment of the same area of the resident's body. An additional note, identified a related concern. One day later, an assessment of the area of the resident's body was conducted on all three shifts and documented accordingly. The following day, the DOC documented an assessment of the area of the resident's body and noted that the physician was informed and that the MD (Medical Doctor) would assess the area in two days time and that staff were to monitor the medical condition. A note five days later indicated the start treatment for the medical condition and there was no documentation of the purpose of the treatment or an assessment of the medical condition was recorded. On that same day, a measure of one of the resident's vital signs documented. No further assessments of the area of the resident's body were documented or located until seven days later when the MD assessed the area of the resident's body.

During the inspection, Inspector #196 conducted an interview with the DOC. The DOC reported that the registered staff should have checked and assessed the resident in relation to the medical condition every shift and documented a progress note of the assessment. Inspector #196 and the DOC reviewed the progress notes for resident #009 and the DOC confirmed to the Inspector that the monitoring of the medical condition had not been documented every shift. There were a total of 35, eight hour shifts, in which an assessment of the medical condition was not recorded, in the progress notes from the date of onset through to the last assessment.

Inspector #196 reviewed the licensee's policy titled Review of "Infection Surveillance - Ontario - IPC-J-10-ON" revised May 2014. The policy identified that the unit Nurse/designate will be responsible for documenting signs and symptoms of infection in the Resident's Interdisciplinary Progress Notes. [s. 19.]

2. During the inspection, the homes' "Daily Infection Control Surveillance Form" was reviewed by Inspector #196. Resident #008 was identified on the form as having a specific medical condition and the onset date and treatment initiation date was not noted.

The health care records for resident #008 were reviewed by Inspector #196. The progress notes on a specific date indicated the resident's development of a specific medical condition and noted that the RN would be informed and a note for the MD (Medical Doctor) was made.

Five days later, a note indicated that treatment was started. Eleven days later, there was an assessment of the specific medical condition and it identified that the condition was getting worse. The following day, an assessment of the medical condition was done by the RN and noted that the MD was to be informed the following day shift.

During the inspection, Inspector #196 conducted an interview with the DOC. The DOC reported that the registered staff should check and assess the medical condition every shift and document a progress note of the assessment. Inspector #196 and the DOC reviewed the progress notes for resident #008 and the DOC confirmed to the Inspector that the monitoring of the medical condition had not been documented every shift. There were a total of 44, eight hour shifts, in which an assessment of the medical condition was not recorded in the progress notes. [s. 19. (1)]

3. The licensee has failed to ensure that residents were protected from abuse by anyone and were not neglected by the licensee or staff.

Three Critical Incident System (CIS) reports were submitted to the Director in the spring of 2016 for staff to resident abuse and neglect. All three incidents identified PSW #124 as the alleged abuser.

The first CIS report was for an incident of staff to resident verbal abuse which had

occurred on a specific day.

According to the report, PSW #123 had overheard PSW #124 yelling at resident #001. In addition, the report indicated that resident #001 was observed to be upset with what had been told to them.

The second CIS report was for an incident of staff to resident abuse/neglect which had occurred on a specific day, six days after the first incident.

According to the report, PSW #124 had told resident #012 that they should be wearing a specific type of continence product and then did not provide assistance to the washroom when the resident had asked. The report also noted that PSW #124 did provide a bed pan to the resident a couple of hours after first being asked for washroom assistance although the resident was able to get to the washroom if assisted.

The third CIS report was for an incident of staff to resident verbal abuse which had occurred on a specific day, six days after the first incident.

According to the report, resident #013 had rang the call bell for assistance and PSW #124 responded by belittling the resident.

Inspector #196 conducted an interview with the DOC regarding the home's investigation into the abuse incidents. They confirmed to Inspector #196, that all three occurrences had not been immediately reported to the Director. In addition, they confirmed that PSW #124 continued to work after the first incident of verbal abuse on a specific day, after the second incident of neglect/abuse and third incident of verbal abuse which both occurred six days later.

The employee records for PSW #124 were reviewed by Inspector #196. A letter identified all three identified incidents and subsequent termination from the home.

Non-compliance pursuant to LTCHA, 2007 S.O. 2007, s.19(1) had previously been issued under inspection report #2015_246196_0016, which included a compliance order served February 12, 2016, and under inspection report #2014_246196_0017, which included a voluntary plan of correction in September 2014.

The decision to re-issue this compliance order was based on the scope of this issue,

which involved a pattern of residents; the severity which identified that minimal harm or potential for risk of harm occurred; and the compliance history, which despite previous non-compliance has continued in this area of the legislation.

(196)

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

Nov 18, 2016

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0007, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The home must ensure that the following monitoring mechanisms are completed
and recorded:
a/ monitor the water temperatures once per shift in random locations in which residents have access to hot water.
b/ conduct weekly audits of the water temperature records to ascertain the temperatures are being recorded and are within the appropriate range.

Grounds / Motifs :

1. The licensee has failed to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #002 issued during inspection #2016_333577_0007. The licensee was ordered to ensure that, if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water. This was to be done by June 28, 2016.

Also the home was to ensure that the following monitoring mechanisms were completed and recorded:
1) The Daily Maintenance Audit
2) The Hot Water Temperature Recording daily from different locations within the home
3) The Bath/Shower Water Temperature logs for each home unit, measured and recorded for every resident bath/shower

Inspector #625 reviewed “Air & Water Temperature Charts” dated for a particular month for all four resident home areas in the home. The document template contained locations for staff to obtain water temperature readings from during each shift. Locations listed on the night shift included the Wellness Center, Soiled Utility Room, Medication Room, Clean Utility Room and Housekeeping Closet.

During an interview with Inspector #625, the ESM stated that the locations from which staff were required to obtain water readings every shift, as listed on the “Air & Water Temperature Chart” used by the home, contained location where residents did

not have access to hot water.

During an interview with Inspector #625, the DOC stated that residents did not have access to the all of the locations where the water temperature readings had been taken including the Wellness Center, Soiled Utility Room, Clean Utility Room and Housekeeping Closet.

(2) A review by Inspector #625 of the home's policy "Bathing and Showering – LTC-H-40" last revised March 2016, identified that three water temperature checks were to be completed prior to providing a resident with a tub bath. The first check involved an integrated tub thermometer (if available) or a hand-held thermometer taken while the water was running, the second check involved a hand-held thermometer taken in the water until the temperature reading was steady, and the third check involved immersing the staff member's forearm in the water for at least five seconds.

The policy also identified three checks were required prior to giving a resident a shower. The first check involved checking the water temperature using the staff person's forearm while the shower was running, the second check involved immersing the staff person's forearm in the water stream for at least five seconds immediately prior to the resident entering the shower, and the third check involved placing either the resident's forearm or staff person's forearm in the water stream, again, for at least five seconds before the resident enters the shower.

On a particular day during the inspection, Inspector #625 observed two signs posted in one of the units Spa/Bathing Room. One was titled "Have You Checked Your Shower/Tub Temperatures?" and reminded staff to perform and record three water temperature checks prior to each resident bath or shower as per the home's policy. The second sign was titled "Bath/Shower Water Temperatures" and stated that water temperatures were to be taken before each resident bath using three checks and provided details on how to complete each check.

Inspector #625 then reviewed the "Bath/Shower Water Temperature Log" found in another Spa/Bathing Room. The log was incomplete as it contained 12 entries taken on seven different dates. Ten out of the 11 entries, or 91 per cent of the entries, were incomplete and were missing specific temperature readings and/or checks.

Inspector #625 also reviewed the "Bath/Shower Water Temperature Log" found in another Spa/Bathing Room and Shower/Washroom. The log from the Spa/Bathing

room was incomplete as it contained 32 entries taken on 14 different dates. Eight out of 14 , or 57 per cent, of entries required to be taken prior to the first bath of the day were not completed correctly, as all eight did not have the temperature from the integrated tub thermometer listed, including one entry which also did not have a temperature from the hand-held thermometer listed, as the log indicated was required. The log from the Shower/Washroom contained 34 entries, all of which were completed incorrectly as all did not have three hand/arm checks combined completed, as the log indicated was required.

During an interview with Inspector #625 on August 18, 2016, the DOC acknowledged that both of the units "Bath/Shower Water Temperature Logs" were not complete and/or were not completed correctly.

(3) In addition to the "Bath/Shower Water Temperature Logs" being incomplete, or completed incorrectly, for resident baths and showers, some resident baths and showers contained no documentation that the first checks were completed, when a bath or shower had been provided.

Inspector #625 reviewed health care records for resident #006 which indicated that the resident had a shower on a specific day. A review by the Inspector of the "Bath/Shower Water Temperature Log" for that time period identified that no water temperature checks for resident #006's shower had been recorded.

Inspector #625 reviewed health care records for resident #009 which indicated that the resident had a shower on a specific day. A review by the Inspector of the "Bath/Shower Water Temperature Log" for that time period identified that no water temperature checks for resident #009's shower had been recorded.

Inspector #625 reviewed health care records for resident #020 which indicated that the resident had a bath on a specific day. A review by the Inspector of the "Bath/Shower Water Temperature Log" for that time period identified that no water temperature checks for resident #020's bath had been recorded.

During an interview with Inspector #625, the DOC acknowledged that resident #006 had a shower on a specific day, resident #009 had a shower on a specific day, and resident #020 had a bath on a specific day, but that the corresponding water temperature checks had not been recorded on the "Bath/Shower Water Temperature Log".

Non-compliance pursuant to O.Reg.79/10, r.90.(2)(k) had previously been issued under inspection report #2016_333577_0007, which included a compliance order served June 14, 2016.

The decision to re-issue this compliance order was based on the scope of the issue, which was a pattern a residents, the severity which identified that minimal harm or potential for risk of harm occurred; and the compliance history, which despite previous non-compliance has continued in this area of the legislation.

(625)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Nov 18, 2016

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2015_433625_0002, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber

Grounds / Motifs :

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

As part of this Follow Up Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection #2015_433625_0002. The licensee was ordered to do the following by December 4, 2015:

(a) Ensure that drugs were administered to resident #001, and every other resident living in the home, in accordance with the directions for use specified by the prescriber including, but not limited to, the correct number of doses, the correct administration times and the correct instructions for use; and
(b) Ensure all registered nursing staff were familiar with and adhered to the licensee's policies governing the processing of medication orders and administration of medications.

The licensee has failed to comply with the order, specifically related to the same resident identified in Critical Incident System Inspection report #2015_433625_0002, Compliance Order #001.

During the inspection, Inspector #625 reviewed resident #001's health care record, which included a "Physician's Digiorder" from a particular day in the winter of 2015. The order had discontinued a specific medication. Resident #001's electronic Medication Administration Record (eMAR) for one particular month in the summer of 2016 listed the previously discontinued medication. The resident's health care record did not contain a current order for this medication despite the entry listed on the current eMAR and signed for as administered on four separate dates in the summer of 2016.

During an interview with Inspector #625, RPN #109 reviewed resident #001's health care record but was not able to locate a current physician's order for the specific medication as was listed on the eMAR.

A review by Inspector #625 of the home’s policy “Medication Administration – LTC-F-20” revised January 2016, identified that the medication administration process was to comply with all applicable professional standards of practice, accreditation standards, provincial legislation and pharmacy policies to ensure safe, effective and ethical administration of medications.

A review by Inspector #625 of the home’s pharmacy provider’s “Guide to Processing eMAR Orders” identified that a nurse was to enter into eMAR when an order was discontinued orders or placed on hold. A second nurse was to ensure the accuracy of the order entered into the eMAR by the first nurse or pharmacy.

During an interview with Inspector #625, the DOC stated that the entry for this specific medication listed on resident #001’s eMAR for the month in which the medication was given four times, was not currently ordered by the physician, and it had been discontinued on a specific date in the winter of 2015. The DOC stated that staff had not followed the pharmacy provider’s policy as the first nurse who processed the order had not discontinued the order on the eMAR, and the second nurse who conducted a second check of the order had not verified the accuracy of the processing of the order on the eMAR. [s. 131. (2)]

Non-compliance pursuant to O.Reg.79/10, r.131.(2) had previously been issued under inspection report #2015_433625_0002, which included a compliance order served November 13, 2015.

The decision to re-issue this compliance order was based upon the scope which was isolated to one resident, the severity which indicated minimal harm or potential for actual harm and the compliance history, which despite previous non-compliance has continued in this area of the legislation.

(625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Nov 30, 2016(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 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 10 day of November 2016 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LAUREN TENHUNEN - (A1)

Service Area Office / Bureau régional de services : Sudbury