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 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 #/ No de registre	Type of Inspection / Genre d'inspection
Feb 28, 2018;	2018_652625_0001 (A2)	025462-17	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

TIFFANY BOUCHER (543) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

This order has been closed due to the fact that this licensee is no longer responsible for the management of this long-term care home as March 01, 2018. The new licensee will be responsible to ensure compliance with the Long-Term Care Homes Act, 2007, as per the conditions of their licence.

Issued on this 28 day of February 2018 (A2)

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

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

TIFFANY BOUCHER (543) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): January 10, 11, 12 and 15, 2018.

During this inspection, one intake was inspected related to a complaint regarding the plan of care, medication administration and care conferences.

During the course of the inspection, the inspector(s) spoke with residents, a substitute decision-maker, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Nursing Secretary, the Registered Dietitian (RD), the Associate Director of Care (DOC), the Director of Care (DOC) and the Executive Director (ED).

The Inspector also conducted tours of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspector also reviewed relevant a health care record, written complaints, correspondence from the home, legal documents and policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication

Personal Support Services

Sufficient Staffing

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

2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

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).

Findings/Faits saillants :

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 were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was received by the Director related to resident #001's medical condition and the administration of a medication to the resident.

Inspector #625 reviewed related documents forwarded to the Director by the home, including a written complaint from substitute decision-maker (SDM) #100 to the home. The complaint indicated that SDM #100's family member, SDM #101, had been contacted on a particular date in the fall of 2017, by Registered Practical Nurse (RPN) #102, to inform them of resident #001's health status. The complaint identified that SDM #101 learned that the resident had experienced symptoms related to a medical condition and was administered a medication only after specifically asking RPN #102, as the home had not contacted the family to inform them.

During a phone interview with Inspector #625, SDM #100 stated that they had not been notified of a change in resident #001's condition, the administration of the medication to treat the condition and the resulting side effects of the medication administration until days after the occurrence.

A review of resident 001's health care record included:
- The Medication Administration Record (MAR) for a particular month in the fall of 2017, which identified a medication was to be administered for a medical condition, and that the medication was administered in the morning of the particular date in

the fall of 2017;
- Progress notes entered on a particular date in the fall of 2017, that indicated resident #001 exhibited symptoms related to the medical condition and administration of the medication; and
- A progress note entered by RPN #102 on the day following administration of the specific medication, that identified the resident had been exhibiting a symptom and a message had been left for SDM #102. A second progress note entered by RPN #102 on the same date, which identified that SDM #101 had returned the home's phone call and would be attending the home to see the resident.

During an interview with Inspector #625, RPN #102 acknowledged that resident #001 had exhibited symptoms related to a medical condition on a particular date in the fall of 2017. The RPN stated that they had worked at particular times for two dates following the exhibited symptoms. The RPN stated that the phone call with SDM #101 the day following the exhibited symptoms was the first time the resident's family had been notified of the resident's symptoms, but that the SDMs should have been notified during a particular time frame on the same day the symptoms were exhibited.

During an interview with Inspector #625, Director of Care (DOC) #103 acknowledged that resident #001 had exhibited symptoms related to a medical condition on a particular date in the fall of 2017, but that the resident's SDMs were not notified of the symptoms until the following date. The DOC acknowledged that the resident had not exhibited the symptoms for a specific period of time and the family should have been notified of the symptoms on the date that they had occurred.

During an interview with Inspector #625, Executive Director (ED) #104 acknowledged that resident #001's SDM(s) had not been given an opportunity to participate fully in the development and implementation of the resident's plan of care with respect to interventions related to the medical condition and the administration of a medication. [s. 6. (5)]

2. A complaint was received by the Director related to resident #001's plan of care, specifically regarding monitoring of a health condition. The complaint alleged that resident #001 had related health issues in the past and monitoring had not be completed for resident #001 in excess of a particular period of time.

Inspector #625 reviewed a written complaint, from SDM #100 to the home that

indicated, at a meeting regarding resident #001, it was determined that monitoring for a medical condition had not been done for a particular period of time, and that it was concerning to the SDM as they had been told that it would be monitored.

The Inspector also reviewed a written response from the home to the complainant. The letter identified that an order to monitor the resident's medical condition was obtained from the physician on a particular date in the fall of that year, the resident refused a monitoring activity on two particular dates and there would be no monitoring activity available on a third particular date, but another attempt would be made to complete the monitoring activity for the resident multiple weeks after the order from the physician had been obtained. The letter stated the home would contact SDM #101 in advance to see if they were willing and able to assist with the monitoring activity.

During a phone interview with Inspector #625, SDM #100 stated that the monitoring had previously been completed at a particular frequency in a specific year; the monitoring had not been completed for a specific amount of time and the SDM(s) had not been notified that the monitoring had been discontinued, or that the home had not completed the monitoring for weeks after it was requested.

A review of resident #001's health care record included:
- Reports that contained monitoring results. The reports were completed eight times in one year; ten times in the following year (ending on a particular date in the fall of that year) and nine times in the following year (beginning on a particular date in the fall of that year);
- A physician's order to discontinue the monitoring dated a particular date in the fall of a particular year; and
- The next chronological physician's order related to the monitoring, to conduct the monitoring activity, on a particular date in the fall of the next year.

During an interview with RPN #102, they stated to the Inspector that, if there had been a change in the monitoring ordered, including the frequency of the monitoring ordered, resident #001's family should have been notified of the change.

During an interview with Inspector #625, DOC #103 indicated that the specific monitoring was discontinued on a particular date in a particular year, and that there was no record that resident #001's SDM was notified of the discontinued monitoring. The DOC stated that the resident's SDM should have been notified of the order to discontinue the monitoring.

During an interview with Inspector #625, ED #104 stated that, resident #001's SDM had not been given an opportunity to participate fully in the development and implementation of the resident's plan of care with respect to a specific monitoring activity. [s. 6. (5)]

Additional Required Actions:

(A2)The following order(s) have been rescinded:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when a written complaint concerning the care of a resident or the operation of the long-term care home was received, it was immediately forwarded to the Director.

A complaint regarding resident #001 was received by the Director.

During an interview with Inspector #625, SDM #100 stated that they had submitted a previous complaint in a specific year, which they believed the Ministry of Health and Long-Term Care had been notified of.

Inspector #625 reviewed written complaints from SDM #100 to the home on four dates in a specific year. The Inspector also reviewed the home's written final responses to each complaint. Each written response indicated that the letter had been copied to the "Ministry of Health and Long Term Care".

Inspector #625 reviewed the written complaints forwarded to the Director by home in the specific year and was not able to locate records that indicated the written complaints concerning resident #001 had been forwarded to the Director.

During an interview with Inspector #625, ED #104 stated that the home was not able to provide verification that the written complaints from SDM #100 to the home in that particular year had been forwarded to the Director. [s. 22. (1)]

Issued on this 28 day of February 2018 (A2)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543) - (A2)

Inspection No. / No de l'inspection : 2018_652625_0001 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 025462-17 (A2)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Feb 28, 2018;(A2)

Licensee / Titulaire de permis :
Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, L4W-0E4

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 : Jonathon Riabov

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

(A2)
The following Order has been rescinded:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28 day of February 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TIFFANY BOUCHER - (A2)

Ontario

Ministry of Health and Long-Term Care

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Service Area Office / Bureau régional de services : Sudbury