**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**


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

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

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## 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 |
|---|---|---|---|
| Jan 21, 2015; | 2014_211106_0014 (A1) | S-000009-14, 1613-14 | Resident Quality Inspection |

### Licensee/Titulaire de permis

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

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

BIRCHWOOD TERRACE
237 Lakeview Drive R. R. #1 KENORA ON P9N 4J7

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

MARGOT BURNS-PROUTY (106) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The compliance date was not correct and needed to be changed.**

**Issued on this 21 day of January 2015 (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**

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MARGOT BURNS-PROUTY (106) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

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

**This inspection was conducted on the following date(s): August 5, 6, 7, 8, 11, 12, 13, 14, 15, 2014.**

**The following Logs were reviewed as part of this inspection: Log# S-000009-14, S-000302-14/001613-14**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (ESM), Housekeepers, Dietary Service Manager, Cook, Family Members, and Residents.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**

**Accommodation Services - Laundry**

**Accommodation Services - Maintenance**

**Continence Care and Bowel Management**

**Dignity, Choice and Privacy**

**Dining Observation**

**Falls Prevention**

**Family Council**

**Food Quality**

**Hospitalization and Change in Condition**

**Infection Prevention and Control**

**Medication**

**Minimizing of Restraining**

**Personal Support Services**

**Prevention of Abuse, Neglect and Retaliation**

**Recreation and Social Activities**

**Reporting and Complaints**

**Residents' Council**

**Responsive Behaviours**

**Safe and Secure Home**

**Skin and Wound Care**

**Sufficient Staffing**

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

**12 WN(s)**
**8 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. On August 11, 2014, staff member #S-100 reported to inspector #106 that resident # 427 uses their top bed rails for bed mobility and to assist with transferring. The Health Care Record (HCR) for resident #427 was reviewed and their was no documentation found to indicate that the resident had been assessed in regards to bed rail use. The RN and the DOC both told the inspector that residents are not assessed for their bed rail requirements, unless full bed rails are used and then they are considered a restraint.

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

2. On August 12, 2014, the Administrator provided inspector #106 with a copy of the home's bed audit that was completed by Joerns Healthcare Canada on December 8, 2011, the results of which were provided to the home on May 28, 2012. The Administrator reported that the bed systems had not been assessed since this date. The results of the December 2011 audit indicated that 90 beds were tested to determine entrapment concerns and 46 of the beds failed the test indicating there were concerns related to entrapment issues.

On August 12, 2014, during an interview the the Environmental Services Manager (ESM) they reported to the inspector that in the last 2 years approximately 35 beds have been replaced. The ESM was unable to indicate what beds in the home still had entrapment concerns as the audit was completed in 2011, and many residents and beds have since been moved within the home.

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

***Additional Required Actions:***

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

**(A1)The following order(s) have been amended:CO# 001**

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**WN #2: 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:**
**4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. On August 13, 2014, inspector #106 observed the following:
-the call bell for s resident room began ringing at approximately 1235hrs and was not answered until 1247hrs. There was only one staff member visible on the unit at this time
-at 1337hrs resident #902 stated in the main dining room in a clear loud voice, that they would like to go back to bed now. There were 3 staff members nearby. Resident #902, told another staff member they would like to go lay down, the staff member told them okay, but could they wait a few moments. At 1345hrs, approximately 8 minutes after the resident began asking, 2 PSW were observed taking the resident and a lift into the resident's room.
-at 1340hrs resident #501 told a staff member that they would like to go lay down now, the resident was encourage by multiple staff members to stay up and the resident asked to be put to bed multiple times. At 1355hrs, 15 minutes after the resident began to ask to go to bed staff were observed to give them assistance.
- at 1225hrs, resident #491 told the inspector they had not received oral care that day and that their brief was wet. Even though the resident had reported this to staff, the resident said they were still waiting for assistance and that waiting for assistance is a very common occurrence. The resident stated they require 2 staff to assist with their toileting needs and they are told they have to wait until 2 staff are available to provide

assistance.

On August 6, 2014, inspector 106 observed the following:
-at 1340hrs resident #902 asked inspector 106 if they could go lay down in their bed, at 1344hrs the inspector found a PSW and reported that resident #902 wanted to go to bed. The PSW reported that the resident would have to wait until the other PSW was finished with transporting residents from the main dining room. The inspector asked the PSW if they were the only staff member on the unit and they stated that there was another PSW that was currently transporting and they could not assist resident #902 as they are a 2 person assist and the 2 other PSWs were on break.

- at 1350hrs resident #501 asked a staff member if they could go to bed, the inspector over heard the PSW tell resident #501 they would have to wait until someone could come and help them as they required a 2nd staff member to transfer. [s. 3. (1) 4.]

2. Inspector #534 was reviewing personal support care related to hygiene and bathing that was provided to resident #439, #461, #493 and #448. The inspector observed the residents on August 7, 12, 13, and 14, 2014 and noted resident's #439 hair as greasy on multiple resident observations, nail care was not provided for resident #493, and resident #439 was unshaven.

A family member for resident #448 approached inspector #534 to discuss that staff are not able to give resident #448 a bath frequently. They stated that on many occasions there were not enough staff scheduled and resident baths were missed. The family member went on to explain that baths were frequently completed by the family. The staff would assist to transfer the resident in and out of the tub and the family member would ring the call bell in the tub room when they had completed giving the resident their bath. The inspector interviewed staff member #S-100 to confirm if resident hygiene and baths were frequently missed. They stated that they were often short staffed and things like baths and shaving are then not done.

The home failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs, specifically in regards to residents #902, #501, #491, #439, #461, #493, #448, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

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

**Findings/Faits saillants :**

1. On August 11, 2014, inspector reviewed the care plan document for resident #467, under the section in regards to toileting it indicated that the resident requires extensive assistance of one person.

On August 11, 2014, staff member #S-100, told inspector #106 that resident #467 toilets independently and may ring if they require assistance. The RAI MDS assessment indicated that resident #467 is independent for toilet use. On August 11, 2014, resident #467 told inspector #106 that they do not require assistance to the toilet and do that by themself.

The licensee failed to insure that the staff and others involved in the different aspects

of care of the resident collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other [s. 6. (4) (a)]

2. The care plan document for resident #467 has the following interventions in regards to dressing and hygiene/grooming:
-"DRESSING - provide set up help"
-"Pick out a couple appropriate outfits and OFFER CHOICES"
-"HYGIENE/GROOMING: provide CONSTANT SUPERVISION with physical assist . (ie. comb hair, shave.)"
-"document any refusal of treatment"
-"SHAVE DAILY - provide cues and encouragement, shaves self."

On August 11, 2014, PSW staff member # S-101 told the inspector that resident #467 is independent in regards to hygiene, but refuses to conduct personal hygiene on a daily basis. On August 11, 2014, staff member # S-100 indicated that the resident is independent when performing personal hygiene and they do not supervise the resident while they perform personal hygiene tasks.

On August 5, 6, 7, 8, 11, and 12, 2014, the inspector observed the resident multiple times and they had not been shaved, their clothes were not changed daily and their hair did not appear to have been brushed.

The PSW documentation sheets from August 1 to 11, 2014, under the sections titled "Personal Hygiene" and "dressing" indicated that resident #467 was independent for these tasks, the sheets do not indicate the resident was supervised or assisted in anyway by staff. [s. 6. (7)]

3. It had been reported during a staff interview with staff #S-102 on August 7, 2014 that resident #439 had fallen within the last 30 days. The inspector was reviewing the fall prevention strategies set in place in the resident's care plan.

The care plan identified that the resident was to wear "proper and non slip footwear". Inspector #534 noted during resident observations on August 12 and 14, 2014 that the resident had socks on. No grips were noted on the bottom of the socks.

On August 14, 2014 during an interview with staff #S-103 regarding the lack of proper footwear for the resident, it was identified that the resident owned 1 pair of shoes. The shoes had become soiled with feces and were sent to laundry to be cleaned. No

alternative non slip footwear was provided to the resident as fall prevention measure as indicated by the care plan.

The licensee failed to shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to residents #467 and #439, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. During a family interview, a family member for resident #464 reported that the resident's dentures were lost in the laundry 2 years ago and have not been replaced. On August 13, 2014, the DOC reported the following to inspector #577:
-the general process is for staff to document in progress notes, search building, inform family and determine whether family will replace item.
-there is not a specific documentation form for missing property.
-it appears this was not followed up with family.
-will investigate this further with staff. [s. 8. (1)]

2. On August 14, 2014, the DOC and Administrator provided inspector #106 with policy # 09-04-06, titled "Complaints". The DOC and Administrator also clarified that missing items, such as jewelry and money, and laundry would be considered a complaint.

Policy #09-04-06 indicates that if a verbal complaint is not resolved within 24 hours an investigation into the complaint by the Department Manager would be initiated. The policy also indicates that written documentation of the complaint is recorded.

During stage one of the RQI inspection process, several residents identified that they have missing laundry or missing items such as jewelry or money. Staff members interviewed by inspector #106, were not aware of the home's policy regarding complaints and no documentation that conforms with the home's policy was found.

The licensee failed to ensure that where the Act or Regulations requires the licensee of a long-term care home to have, institute or otherwise put in place, any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol procedure, strategy or systems is complied with. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or Regulations requires the licensee of a long-term care home to have, institute or otherwise put in place, any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol procedure, strategy or systems is complied with, specifically in regards to missing items, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. On August 13, 2014 the following was observed by inspector #106:
-In a main corridor and in a common area, the flooring near the walls and under items such as table at front entry and near edge of items such as fish tank stand are stained from ground in dirt
-resident room: has some dried urine spots on the raised toilet seat
-resident room: buildup of dirt around the base of furniture and the legs/feet of the bed; the window had a dried spill and the sill has multiple dried drops of liquid, (possibly Ensure or milk)
-resident room: the light fixture has 20+ dead flies, this was noted on all days of the inspection; the floor near the base of the walls has a build-up of dirt and ground in dirt
-resident room: the raised toilet seat had dried smeared feces on it
-resident room: raised toilet seat had feces on the inner edge and the floor in front of the toilet had urine on the floor
-windows in the front entrance vestibule had multiple streaks and spill marks
-resident room: dried feces on the inside of the raised toilet seat

-a build-up of dirt and or ground in dirt along the entrance base boards of many resident rooms
-thick gunky build-up of dirt along the floor near the base boards in the kitchenette and the wall where the elevator is
-floor is stained by ground in dirt, along the wall the near tv

On August 12, 2014, the following was observed by inspector #106:
-resident room: washroom has dead flies in the light fixture
-resident room: wet urine on the raised toilet seat, floor at the base front of toilet appears damp, observations made at both 1030 and 1230hrs
-resident room: the raised toilet seat had spots of dried feces along the top inner edges

On August 11, 2014, the following was observed by inspector #106:
-resident room: the raised toilet seat was dirty, it had a blood stain on the inside of the toilet seat, the toilet had not been flushed and there was urine in the toilet bowel
-resident room: raised toilet seat had some spots of urine/feces on it and the toilet bowel was full of feces and urine

On August 5, 2014, the following was observed by inspector #106:
-resident room: feces smeared on the toilet seat; multiple food crumbs on the floor
-resident room: feces smeared on the inside of raised toilet seat
-resident room: smeared feces on the raised toilet seat; washroom has a strong urine smell
-resident room: bedside floor mat (for falls) room has multiple spots on it, spots may be dried sputum

The licensee failed to ensure that, the home, furnishings and equipment are kept clean and sanitary. [s. 15. (2) (a)]

2. On all days of this inspection up to August 13, 2014, inspector #106 observed the following:

-resident room: the lower wall along the wall with the door to the washroom has long scuff marks and gouges, in some areas the drywall is showing
-resident room: the dresser nearest the closet has a broken bottom drawer; the heater under the window has multiple scrapes and metal is exposed
-main corridor lower walls has multiple black and dark scuff marks
-in main area beside the clean utility room the lower wall has 3 gouges in the wall, one

gouge is down to the drywall
-the front of the nursing station has multiple black scuff marks along the desk front
-the upholstered chairs in the main dining/tv lounge area have ground in dirt staining the chair and couch arms, seats, backrests and this is extensive on the head rest area on the chair nearest the piano

-unpainted patched drywall in dining area on wall to the front and right of the nursing station, approx. 18" X 8" and a smaller patch down below, larger patches along the wall approximately 6'x 3' and 4" x 18"
-unpainted patched drywall along the wall to the front and left of the nursing station, approximately 6" x 12' (almost length of the wall)
-unpainted patched drywall by the door to room 301
-multiple scuffs along the front of the nursing station
-multiple black and dark scuffs on the lower walls of the main corridor
-upholstered furniture in the main tv/dining lounge have ground in dirt on the arm rests and chairs and couches

The licensee failed to ensure that the the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are kept clean and sanitary and are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The inspector reviewed the skin and wound care interventions for resident #439. During a review of the home’s skin and wound program, the inspector noted that weekly skin assessments were not being documented weekly by the PSW staff as indicated by the home’s skin and wound care program.

In the resident’s care plan binders on the third floor a document entitled “Head to Toe Observation” was noted for each resident in their respective binder area. Directions at the bottom of the page state “To Be Completed By PSW On First Bath Day of Each Week. If Resident refused bath or shower skin observation still needs to be completed. To be completed by Registered Staff as per MOH Regulations”. The inspector asked staff # S-103 about the skin observation tools for the residents in the home. They stated that they were not familiar with the documents and had not filled one out in the past.

The inspector interviewed the skin and wound care lead staff member #S-104 about the “Head to Toe Observation” sheets not being completed; they stated it has been difficult to get the PSW staff to complete and document the skin assessments. They also confirmed that the sheets in the binders were blank for most of the residents.

The inspector further discussed the undocumented weekly skin assessments within the home’s skin and wound program with the Director of Care. They agreed and acknowledged having difficulty with the documentation of the skin assessments being completed in the home by the PSWs. Multiple education and re-education has been completed to explain the purpose of the sheets to the staff and they continue not to be used.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented. [s. 30. (2)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident’s responses to interventions are documented, specifically in regards to resident #439, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. A Critical Incident System (CIS)report submitted to the Ministry of Health and Long Term Care indicates that resident #900 displayed specific responsive behaviours.

On August 5, 2014, inspector #106 reviewed resident #900's care plan document and there were no interventions in place to direct staff on how to manage the resident's specific responsive behaviours.

On August 11, 2014, inspector #106, interviewed the DOC and a RPN in regards to resident #900's specific responsive behaviours and how the home was managing the resident's responsive behaviours. Both the DOC and the RPN detailed how staff are to manage Resident #900's specific responsive behaviours.

The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible. [s. 53. (4) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, specifically in regards to resident #900, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. On August 14, 2014, during a review of the 3rd floor medication room inspector #106 noted that overnight briefs and a vitals machine were stored in the medication room. The inspector asked the staff member #S-105 why there were briefs stored in the medication room and they stated that the briefs used to be stored in another area but staff were using the night time briefs inappropriately so they started to store them in the medication room.

The licensee failed to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. On August 14, 2014, during a review of the Government Drug Stock area the following medications were found to be expired:
-12 bottles of 325 mg, pms-ASA, with expiry date of May 2013
-3 bottles of Tanta brand, “Children's Motion Sickness Liquid”, with expiry date of November 2013
-15 boxes of Sandoz brand, Dimenhydrinate 50 mg, with the following various expiry dates April 2014, November 2013, May 2013, and March 2013
-23 bottles of APO-Acetaminophen 500mg, with various expiry dates of November 2013 and April 2014
-1 box containing 10 - 1ml ampules of vitamin B12 1000mg/ml, with expiry date of April 2013
-24 bottles of Docusate Sodium 100mg, with the various expiry dates of December 2012 and January 2013
-7 bottles of Bronchophan Expectorant, with the expiry date of November 2013
-5 bottles of Dextomethorphan Hydrobromide Syrup, with expiry of March 2013
-24 bottles of Fleet Enemas, with the expiry date of March 2014

The licensee failed to ensure that the drugs are stored in an area or medication cart, that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting). [s. 129. (1) (a)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies and that the drugs are stored in an area or medication cart, that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting), to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

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

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. On August 13, 2014, inspector #106 observed, staff member #S-107, clear dirty dishes from the tables, scrape food debris into the garbage, and transfer dirty dishes between bins and then serve residents dessert without practicing hand hygiene. This was repeated multiple times, between several residents.

The licensee failed to ensure that all staff participate in the implementation of the Infection Prevention and Control Program. [s. 229. (4)]

2. On August 13, 2014, at approximately 1530hrs, inspector #106 observed registered staff member #S-108 administer medications to residents. In excess of 5 times the registered staff member was observed to punch medications out of a medication card into their hand and then place the medication into a med cup before administering to the resident. The registered staff member was also observed to pour Acetominiphen into their hand from a bottle and then place the medication into a med cup before giving it to the resident.

During this same medication pass the registered staff member did not practice hand hygiene prior to or after administering a topical gum medication and eye drops to resident #901, nor did the RPN use gloves when administering the topical gum medication that required her to touch the inside of the resident's mouth.

The licensee failed to ensure the all staff participate in the implementation of the Infection Prevention and Control Program. [s. 229. (4)]

3. Inspector #534 reviewed the resident immunization program in the home and records for 3 residents. During the record reviews for resident #439, #461, and #493, it was noted by the inspector that no documentation or assessment of their tetanus and diphtheria immunizations were found.

The inspector reviewed the homes “Administration Consent Form Birchwood” that requested consent for tetanus and diptheria vaccination but noted that on the home's documents entitled “Initial Immunization Assessment & Ongoing Tool”, the physician's “Annual Medical History and Wellness Examination”, and “Immunization” tab of the home's computer documentation program, diphtheria or tetanus vaccination administration documentation for the residents was not included.

This was confirmed through interviews conducted with staff member #S-106 and the home's director of care. Staff member #S-106 stated that often times when residents are sent to the hospital for treatment, the hospital will call the home for the resident's tetanus administration vaccination date and the home's staff do not know when it was last administered. The DOC agreed that assessment and administration of tetanus or diptheria was most likely not being completed since they were not listed on any of the home's assessment and administration tools.

The licensee failed to ensure that the following immunization and screening measures are in place: residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following immunization and screening measures are in place: residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website and all staff participate in the implementation of the Infection Prevention and Control Program, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The Health Care Record (HCR) for resident #491, was reviewed by inspector #106, specifically in regards to oral care. It was found that the resident requires extensive assistance for personal hygiene (which includes oral care).

On August 13, 2014, at approximately 1230hrs, resident #491 told the inspector they had not received oral care that day. They also reported the same on 2 other days during this inspection (August 5 and 8, 2014).

The PSW documentation work sheets were reviewed from August 1 to 11, 2014, and there was no documentation to indicate that oral care for resident #491 had been done on the following shifts:
Days: Aug 1, 2, 3, 5, 7,8, 10, 11, 2014
Eve: Aug 1, 7, 9, 10, 11, 2014.

The licensee failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures. [s. 34. (1) (a)]

2. On August 15, 2014, Inspector #577 interviewed the DOC concerning annual dental assessments in regards to residents # 481, #464, and #432. They reported that the Home does not have a dentist that comes into the Home and they do not offer residents an opportunity to see a dentist in the community, subject to payment. The Home failed to ensure that an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1). [s. 34. (1) (c)]

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. On August 5, 2014, inspector #106, found:
- Four unlabelled toothbrushes in the shared resident washroom
-One unlabelled toothbrush in the shared resident washroom
The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management**

**Specifically failed to comply with the following:**

**s. 51. (2) Every licensee of a long-term care home shall ensure that,**
**(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

**Findings/Faits saillants :**

1. On August 13, 2014, the inspector asked the DOC where the continence assessments would be found and was told they were in the electronic health care record under the assessment table and indicated that it would begin with "EO". The inspector looked in resident # 467's electronic health care record under the assessment and completed a specialized search for "EO Bladder Continence Assessment" and "EO Bowel Continence Assessment", no completed assessments were found.

The most recent RAI MDS assessment indicated that resident #467 is usually continent of bladder and has less than 1 incontinence episode per week. [s. 51. (2) (a)]

2. The inspector searched in resident # 491's electronic health care record under the assessment and completed a specialized search for "EO Bladder Continence Assessment" and "EO Bowel Continence Assessment", no assessments were found.

The most recent RAI MDS assessment indicated that resident #491 is frequently incontinent of bladder and bowel.

The licensee failed to ensure that the resident who is incontinent received an assessment that: includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [s. 51. (2) (a)]

**Issued on this 21 day of January 2015 (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


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

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

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

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MARGOT BURNS-PROUTY (106) - (A1) |
| **Inspection No. / No de l'inspection :** | 2014_211106_0014 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / Registre no. :** | S-000009-14, 1613-14 (A1) |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Jan 21, 2015;(A1) |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT, 8TH FLOOR,<br>MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | BIRCHWOOD TERRACE<br>237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7 |

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

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

## Order(s) of the Inspector

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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

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** WENDY SARFI

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To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

(A1)
The licensee will comply with O. Reg. 79 10, s. 15. (1) (a) and ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

**Grounds / Motifs :**

(A1)
1. On August 12, 2014, the Administrator provided inspector #106 with a copy of the home s bed audit that was completed by Joerns Healthcare Canada on December 8, 2011, the results of which were provided to the home on May 28, 2012. The Administrator reported that the bed systems had not been assessed since this date. The results of the December 2011 audit indicated that 90 beds were tested to determine entrapment concerns and 46 of the beds failed the test indicating there were concerns related to entrapment issues.

On August 12, 2014, during an interview the the Environmental Services Manager (ESM) they reported to the inspector that in the last 2 years approximately 35 beds have been replaced. The ESM was unable to indicate what beds in the home still had entrapment concerns as the audit was completed in 2011, and many residents and beds have since been moved within the home. (106)

2. On August 11, 2014, staff member #S-100 reported to inspector #106 that resident # 427 uses their top bed rails for bed mobility and to assist with transferring. The Health Care Record (HCR) for resident #427 was reviewed and their was no documentation found to indicate that the resident had been assessed in regards to bed rail use. The RN and the DOC both told the inspector that residents are not assessed for their bed rail requirements, unless full bed rails are used and then they are considered a restraint.

The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. (106)

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

Jan 23, 2015(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
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

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

Health Services Appeal and Review Board  and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 21 day of January 2015 (A1)**

**Signature of Inspector / Signature de l'inspecteur :**

**Name of Inspector / Nom de l'inspecteur :** MARGOT BURNS-PROUTY - (A1)

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