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

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
Mar 30, 2015;	2015_271532_0005 (A1)	L-001826-15	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

COLUMBIA FOREST
650 MOUNTAIN MAPLE AVENUE WATERLOO ON N2V 2P7

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

NUZHAT UDDIN (532) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance dates on order #001, #002, #003 were changed as requested by the Home.

Issued on this 30 day of March 2015 (A1)

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

Original report signed by the inspector.

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NUZHAT UDDIN (532) - (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): February 03, 04, 05, 06, 09, 10, 11, 12 and 13, 2015

Concurrent CIS was completed:00616-15

During the course of the inspection, the inspector(s) spoke with the Executive Director , Acting Director of Care (DOC), Corporate Nurse Consultant, Regional Manager, Associate Director of Cares (ADOC), Resident Services Coordinator, Nutrition Manager, Environmental Service Manager, Dietitian, Program Manager, Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) , Family and Resident Council Representatives, Residents and Family members.

The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures, reviewed educational records, general maintenance of the home, and resident communication system, medication storage areas, and reviewed medication records as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

16 WN(s)
11 VPC(s)
3 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 #9: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A) During stage 1 interview an identified resident revealed that on an identified day an incident had occurred causing an injury to the resident.

Clinical Record review revealed that there was a note documented.

An investigation was done however, the origin of injury was determined as "unknown" at the time.

In an interview the resident was able to provide the names of the Personal Support Worker who assisted the resident with the transfer and the Registered Practical Nurse who assessed the resident the day that the incident took place.

The name of the Registered Practical Nurse was consistent with the Progress Note documentation on Point Click Care and the Personal Support Worker (PSW) name was confirmed through direct interview process.

A follow-up was done with a Personal Support Worker who was present at the time of incident and the PSW reported that they did not believe the identified resident and that the identified incident could cause an injury. The PSW further reported that they failed to examine the resident for an injury and did not notify the charge nurse concerning

the incident.

The ADOC confirmed that the staff member was educated on Abuse and the Bill of Rights and was aware of reporting protocols.

The licensee failed to ensure that the resident was treated with courtesy and respect when the staff member failed to believe the resident and failed to report the incident to a Charge Nurse. [s. 3. (1) 1.]

2. The licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted: 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Observation of noon Medication pass on an identified Home Area revealed the following:

Five identified Residents had an order for a treatment and the treatment was administered in the dining room/nurse's station in front of other residents.

The ADOC confirmed that the treatments were not to be given in front of other residents in the dining room and if the residents requested to have the treatment provided to them in the dining room then it would be reflected in their plan of care.

Record review stated that the treatments for the above residents were not documented in the plan of care.

The ADOC confirmed that the residents have the right to be afforded privacy in treatment and in caring for their or personal needs. [s. 3. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, to be implemented voluntarily.

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

s. 6. (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).

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

Findings/Faits saillants :

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

A) An identified resident was observed on two different dates with an assistive device in place.

The assistive device was observed as not applied correctly.

A Personal Support Worker confirmed that the assistive device was applied incorrectly

and adjusted it to a correct position.

The identified resident's plan of care directed staff to apply the assistive device as per manufacturer's instructions.

The Acting Director of Care reported that the home did not have manufacturer's instructions however; the application of the device would be covered during the education.

The Assistant Director of Care (ADOC) responsible for education reported that the application of the device was not included in the education provided to staff.

The plan of care did not provide clear direction to staff providing care on how to apply the PASD. [s. 6. (1) (c)]

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

A) Record review revealed that a Registered Nurse had sent a referral to the home's Physiotherapist regarding a possible use of an assistive device for an identified resident.

A review of the clinical health record indicated that the Physiotherapist reassessed the resident. The Physiotherapist indicated that the use of the assistive device was not a good option.

On two different occasions the resident was observed to have the assistive device applied.

The Registered Nurse confirmed that the resident had assistive device applied.

The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other. [s. 6. (4) (b)]

3. The licensee has failed to ensure that the care set out in the plan of care is

provided to the resident as specified in the plan.

A) The plan of care for an identified resident indicated that an identified assistive device was to be used.

The Resident was observed with an Assistant Director of Care (ADOC) in attendance, to have the wrong number of assistive devices in place.

The ADOC confirmed that only one of the assistive devices was to be used at the time of observation.

The licensee failed to ensure that care was provided for an identified resident as specified in the plan of care. (192)

B) An identified resident was noted to have physical limitations.

Upon review of the Physician Orders it was noted that there was an order for a specified intervention.

Record review revealed that the specified interventions were noted in the plan of care.

Upon two separate observations, it was noted that the interventions were not in place as per plan of care.

Upon interview with a Personal Support Worker, it was confirmed that the resident did not have the identified interventions and care set out in the plan of care was not provided to the identified resident as specified in the plan. (519)

C) The plan of care for an identified resident indicated that one staff member was to provide assistance with Activities of daily livings when the identified resident was showing signs of fatigue.

The plan of care further indicated different interventions.

On identified date the resident was observed as tired and the assistance was not provided as per plan of care.

Interview with two Personal Support Workers confirmed that the resident was fatigued, the assistance was not provided and the interventions were not offered and the care

set out in the plan of care was not provided to the resident as specified in the plan.

D) An identified resident's plan of care related to nutrition indicated that staff would make a referral to the Registered Dietitian if less than required meal was consumed or if fluid intake was less than required for three consecutive days.

A review of the resident's clinical health record and confirmation from the Registered Dietitian indicated that the identified resident had a daily fluid requirement.

A review of the resident's fluid records indicated that the resident consumed less than the daily requirement.

The Registered Dietitian confirmed that they did not receive a nutrition referral to assess the resident's hydration and would expect a referral for this resident since fluid intakes were consistently below the requirements.

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

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident’s care needs change or care set out in the plan was no longer necessary.

A) A review of clinical record for an identified resident indicated that the resident experienced a change in condition.

A review of the clinical records indicated that the identified resident had variable intake consuming less than the required amount on numerous occasions.

A review of the clinical record indicated that there was no nutritional reassessment completed by the Registered Dietitian from the resident's admission assessment until the quarterly reassessment.

The Registered Dietitian confirmed that there was no nutrition reassessment completed during the identified period of time.

The resident was not reassessed and the plan of care reviewed and revised at least every six months when the resident's care needs changed. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan had not been effective.

A) A review of an identified resident clinical health record indicated that the resident was receiving interventions since their admission to the Home.

A record review indicated that the identified resident had refused the prescribed interventions and had only taken it on a few occasions. This was confirmed by the Registered Practical Nurse.

A record review indicated that the resident had been refusing the prescribed interventions on a regular basis for at least the past five months.

The identified resident reported that they did not want the prescribed interventions daily as it no longer appealed to them.

Interview with the Registered Dietitian confirmed that a nutrition reassessment was not completed when care set out in the plan had not been effective. [s. 6. (10) (c)]

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, clear directions to staff and others who provide direct care to the resident and to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and are consistent with and complement each other and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan is not effective, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

A) An observation of controlled substance revealed that there was a stationary red bin for controlled substances for destruction located inside the medication room inside an unlocked cabinet.

Upon further observation it was noted that the red bin had a huge slot on top where the controlled substance for destruction would go and a key lock in the front.

The Inspector was able to put her hand through the slot and pulled out the controlled substances (injectables and pills) in front of the Registered Nurse.

The Acting Director of Care (DOC) was called up to the home area and same controlled substances were pulled out in front of the ADOC.

In an interview the ADOC confirmed that controlled substances were to be stored in a separate and secured double-locked bin.

The ADOC confirmed that the pharmacist was coming to the home for drug destruction and the red bin would be removed and changed to ensure safe storage of drugs and the controlled substance would be stored in a separate, double-locked stationary cupboard in a locked area. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A bed evaluation was completed in the home in March 2014 and beds were identified to have failed entrapment testing in zones 2, 3, and 4. Changes were made to the beds including the addition of new mattress surfaces and the removal of some bed rails.

Interview with an Associate Director of Care confirmed that there was no record of reassessment when changes to beds were made following the March 2014 assessment.

A bed survey conducted by the home identified that 66 of 156 (42%) beds in the home have bed rails attached. The document does not identify the zones entrapment or

whether the beds achieved a pass or fail for in testing for entrapment.

Interview with the Executive Director identified that this list was just being initiated and did not include re-evaluation of all bed systems.

Interview with the person initiating the list confirmed that the identified record was the most up to date list, including changes made to beds since the March 2014 evaluation and confirmed that zones of assessment had not been assessed using the recommended tool.

Interview with the ADOC identified that they had not received training on the assessment of beds for entrapment.

The home's policy titled Resident Bed System/Entrapment, indicated that all bed systems were to be evaluated annually, at a minimum, for zones of entrapment.

Observation of the bed occupied by an identified resident identified that both bed rails were in the raised position. The mattress was noted to move readily with light pressure laterally and a potential entrapment risk was evident at the distal end of the bed rail. The assessment of the bed used by the resident identified that only one rail was in use.

Observation of the bed occupied by an identified resident identified use of two quarter rails in the up position. Observation confirmed by an ADOC identified that the bed rail on the resident's right side was loose fitting and presented a potential entrapment hazard for the resident.

Observation of the bed occupied by an identified resident during stage one and two of this inspection that the mattress moved laterally on the bed frame allowing a gap greater than six inches between the mattress and the end of the bed rail. No mattress stoppers were observed and a gap of four inches was observed at the foot of the bed when the mattress was pushed to the top of the frame. Review of the entrapment checklist completed indicated that mattress stoppers were in place and that the mattress covered the entire length and width of the bed frame.

The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 003

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 bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. r. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: 1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. 2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. 3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. 4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg.

79/10, s. 30 (1).

A) A review of the annual program evaluation for continence indicated that the evaluation was successful.

In an interview the ADOC shared that the continence evaluation was deemed successful based on the products and supplies used by the residents only.

The ADOC confirmed that the goals, objectives, relevant policies, procedures, protocols and the assessments were not reviewed as part of the program evaluation. She shared that she understood why the entire program needed to be evaluated.[s. 30. (1) 2.]

2. The licensee failed to ensure that the laundry, housekeeping and maintenance program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) During stage one of this inspection residents identified that clothing items had gone missing from the laundry department and that they had reported the missing items to staff of the home.

Interview confirmed that a policy related to missing clothing was in place in the home, but that the effectiveness of the home's policy had not been evaluated.

Interview with the Executive Director confirmed that the missing items should be monitored as part of the Quality Program and that Missing Clothing Checklists should become a permanent part of the resident's record.

Interview with the Executive Director confirmed that the laundry, housekeeping and maintenance program contracted to Compass Group Canada had not been evaluated and updated.

No record of evaluation could be provided in relation to these programs. [s. 30. (1) 3.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A) An identified Resident was determined as being at high risk for falls.

Record review revealed that interventions were put in place on admission to prevent falls.

Record review indicated that the resident was complaining of pain in the identified location and they were found to have a specific injury.

Due to the resident's complaints the Registered Practical Nurse on duty assessed the resident and noted an injury. The Registered Nurse on duty during the night shift also assessed the resident and could not determine the cause of the pain.

An assessment was not initiated using a clinically appropriate assessment instrument and the identified resident was sent to the hospital.

Record review confirmed that the Resident had an injury.

Upon interview with the Acting Director of Care it was confirmed that after the home's investigation it could not be determined how the Resident sustained an injury. She confirmed that the home suspected a fall that had not been reported by a staff member. She also confirmed that an assessment should have been initiated using a clinically appropriate assessment instrument immediately after it had been discovered.

ADOC confirmed that the resident did not have a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (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 when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

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

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A) A review of an identified resident clinical assessment indicated that the resident resisted care daily and displayed responsive behaviours.

The identified resident's assessment indicated the resident resisted care and displayed responsive behaviours at least one to three days in the last seven days.

Clinical record indicated that the resident was resistive to having a activities of daily living and can display responsive behaviour.

Interview with the RAI Coordinator confirmed that the resident's plan of care did not include the identified resident's responsive behaviour.

B) Record review indicated that an identified resident exhibited responsive behaviours and this behaviour would be care planned.

A documentation review identified that the resident displayed responsive behaviours number of times in an identified period of time.

Interview with a Personal Support Worker confirmed that the resident displayed responsive behaviours .

Interview with the RAI Coordinator confirmed that the resident's plan of care was not based on the resident's assessment and did not include the responsive behaviours.

The licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including any identified responsive behaviours. [s. 26. (3) 5.]

2. The licensee has failed to ensure that the plan of care was based on the interdisciplinary assessment of the resident's sleep patterns and preferences.

A) In an interview an identified resident indicated that they did not sleep well due to loud noise and the roommate was noisy.

Record review indicated the resident complained of not sleeping well with early morning wakening about 4 AM.

Record review indicated that resident was started on a medication and the resident found it helpful.

Record review stated that there was no plan of care related to sleep patterns and preferences.

The ADOC confirmed that there should be a plan of care for the resident based on the interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

3. The licensee failed to ensure that a Registered Dietitian who was a member of the staff of the home assessed nutritional status, including height, weight and any risks relating to nutrition care.

A) A review of an identified resident clinical health record indicated that the resident required as needed medication on five occasions.

Interview with the Registered Dietitian confirmed that a nutrition referral related to constipation was not received for this resident, a reassessment of the residents bowel management was not completed and the resident currently did not receive nutrition and hydration interventions related to constipation.

The licensee failed to ensure that the Registered Dietitian assessed constipation relating to nutrition care. [s. 26. (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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day and to ensure that a Registered Dietitian who is a member of the staff of the home assesses nutritional status, including height, weight and any risks relating to nutrition care, to be implemented voluntarily.

WN #10: 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 licensee of the long term care home 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.

A) A review of an identified resident clinical health record and bathing schedules indicated that the resident was scheduled for a bath twice a week.

A Personal Support Worker interviewed reported that they had showered the resident four days prior, that the resident was scheduled to be bathed on that evening and that all residents should receive two baths per week.

The Personal Support Worker reported that the resident was ill for a period and received bed baths at that time however, the resident currently received showers. The Personal Support Worker reported that if the resident refused staff would have to document it.

Bathing records reviewed with the Associate Director of Care confirmed that the resident received one bath for the identified dates and no refusals of bath were noted in the past 30 days.

The Associate Director of Care confirmed that the resident was not bathed at a minimum twice per week. [s. 33. (1)]

Additional Required Actions:

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

WN #7: 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. The licensee has failed to ensure that the resident who was incontinent received an assessment that:
included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review for an identified resident stated that the Resident was a recent admission to the Home.

A review of resident's record revealed that the resident was assessed as being frequently incontinent of bladder, tended to be incontinent daily, but some control present and occasionally incontinent of bowel as once a week.

Record review with a Registered Nurse(RN) and the Acting Director of Care(DOC) identified that the resident did not have a continence assessment completed upon admission.

In an interview an RN shared that they reviewed the admission checklist when completing the Admission/Quarterly Continence Assessment(ON) and confirmed that the checklist did not have the Admission/Quarterly Continence Assessment (ON) listed as one of the assessment to be completed.

The Admission/Quarterly Continence Assessment (ON) was further reviewed for bowel assessment and it was noted that the assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions related to bowels.

The Corporate Nurse confirmed that the bowel assessment was not included in the Admission/Quarterly Continence Assessment (ON) and shared that the policy will be reviewed.

The ADOC confirmed that the Admission/Quarterly Continence Assessment (ON) was not completed for the Resident upon admission and the Home does not have a Continence Assessment related to bowels. [s. 51. (2) (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 the resident who is incontinent received an assessment that:
included 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, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept relating to the evaluation of the responsive behaviour program.

A) Interview with the Assistant Director of Care responsible for responsive behaviours confirmed that there was no written program evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented for 2014. [s. 53. (3) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Record review indicated that an identified resident sustained a altered skin integrity on two different occasions.

Record review stated that both altered skin integrity were documented in Progress Notes.

Record review indicated that there was no head to toe assessment or skin assessment completed upon the discovery of the two altered skin integrity.

In an interview the Wound Care Nurse confirmed that there should have been an assessment completed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.(532)

B) The home's skin and wound care nurse reported that when a resident sustained altered skin integrity that a head to toe assessment should be completed by registered nursing staff.

A review of an identified resident's clinical health record indicated that the resident sustained altered skin integrity however, there was no head to toe assessment completed by registered nursing staff. This was confirmed by the skin and wound care nurse who reported there should have been a head to toe assessment completed by registered nursing staff.

C) An identified resident sustained altered skin integrity however, review of the resident's clinical health record indicated there was no head to toe assessment completed by registered nursing staff, this was confirmed by a Registered Nurse.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Clinical record review for an identified resident indicated that the resident sustained

a altered skin integrity.

Review of the clinical health record with the Registered Practical Nurse confirmed that there were no weekly reassessments completed by a member of the registered nursing staff.

The Registered Practical Nurse reported that weekly assessments should have been completed for the identified weeks.

The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

On two different occasions an identified resident was observed to have an assistive device in place and this was confirmed by a Personal Support Worker responsible for providing the resident care.

A review of the clinical health record indicated that the use of the assistive device was not included in the resident's plan of care.

The Registered Nurse confirmed that the use of the assistive device was not included in the resident's plan of care, that a physician/registered nurse in the extended class had not ordered or approved the assistive device and that the consent by the substitute decision-maker of the resident had not been attained.

The licensee has failed to ensure that a resident may be restrained by a physical device if the restraining of the resident was included in the resident's plan of care. [s. 31. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

A) The home's policy Nutritional Supplements and Prescribed Snacks, indicated that unconsumed nutritional supplements and prescribed snacks would be communicated to the Nutrition and Culinary Service Department and documented. The Registered Dietitian would update the resident's care plan and reassess the need, tolerance and acceptance for nutritional supplement/prescribed snacks usage on an ongoing basis.

A review of an identified resident's clinical health record indicated that the resident was receiving an intervention which was recently changed to something a different.

A review of nourishment records indicated that the resident consistently refused the prescribed interventions.

The Registered Dietitian confirmed that they did not receive a nutritional referral for unconsumed prescribed interventions and as a result, no reassessment was completed.

The licensee of the long term care home failed to comply with their Nutritional Supplements and Prescribed Snacks policy.

B) The home's Skin and Wound Care Program policy, indicated that a referral to the Registered Dietitian would be completed.

The home reported that when residents sustain altered skin integrity the home's policy was to refer to the Registered Dietitian.

An identified resident had altered skin integrity however, there was no referral completed to the Registered Dietitian and this was confirmed by the skin and wound care nurse.

The licensee has failed to ensure that the Skin and Wound Care Program policy was complied with.

C) Policy named Administering and Documenting Controlled Substances stated that “ each dose of every controlled substance is accounted for on an individual Narcotic sheet/record and MAR sheet.

Observation revealed that two identified Residents were on a controlled substance.

The medication cards for the controlled substance and the shift count sheet both corresponded.

The individual controlled substance count sheet was reviewed with the RPN and it revealed a different count.

In an interview the RPN confirmed that the medication was signed out but it was not accounted for on the individual narcotic record.

The Acting Director of Care confirmed that the expectation was to document the controlled substance medication as administered, immediately after administration and the policy was not complied with.

D) The home's bowel protocol confirmed by a member of the Registered Nursing staff, indicated that if the resident did not have a bowel movement on day two staff were to provide a laxative at night, if there was no bowel movement on day three staff were to provide a laxative or suppository in the morning, if no bowel movement by night staff were to provide a laxative, if no bowel movement by day four staff were to provide a fleet enema and if still no bowel movement staff were to contact the physician.

A review of an identified resident clinical health record indicated that the resident required interventions for bowels.

A review of the identified residents clinical records indicated that the resident did not have regular bowel movements.

The Registered Practical Nurse confirmed that the resident did not receive interventions as per bowel protocol

The licensee has failed to ensure that the home's bowel protocol was complied with. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the planned menu items were offered and available at each meal and snack.

A) During a meal service in an identified home area, it was observed that an identified resident was removed from the dining room prior to being offered a dessert.

Another identified resident was observed during a meal service to eat independently at a slower pace. The resident remained at the lunch table until their lunch plate was removed. Dessert was not offered to the resident at this time.

Interview with the Personal Support Workers confirmed that dessert was not offered to these residents during the lunch meal. [s. 71. (4)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented was promptly prepared.

A) Interview with the Acting Director of Care confirmed that a written evaluation of restraints was completed in conjunction with the home's annual program evaluation of falls.

A review of the annual program evaluation of falls indicated that the evaluation of the home's restraint program did not include a written record of everything provided for in clauses (a), (b) and (d). This was confirmed by the Acting Director of Care. [s. 113. (e)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee of the long term care home failed to ensure that the home was equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

An identified resident was observed sitting in a chair on the far side of the room closest to the window. The resident's call bell was not accessible.

The plan of care related to falls indicated that the call bell should be within reach when leaving the resident in their room.

A Personal Support Worker reported that the resident's call bell should be within reach of the resident and verified that the call bell was not accessible to the resident.

The licensee of the long term care home failed to ensure that the resident-staff communication and response system was easily seen, accessed and used by residents, staff and visitors at all times. [s. 17. (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 the home is equipped with a resident-staff communication and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

Issued on this 30 day of March 2015 (A1)

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

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) : NUZHAT UDDIN (532) - (A1)

Inspection No. / No de l'inspection : 2015_271532_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-001826-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Mar 30, 2015;(A1)

Licensee / Titulaire de permis :

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

LTC Home / Foyer de SLD :

COLUMBIA FOREST
650 MOUNTAIN MAPLE AVENUE, WATERLOO,
ON, N2V-2P7

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Ruthanne Lobb

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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:

Order # / Ordre no : 001

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

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 must ensure that the care set out in the plan of care is provided to the residents #004, #039 and #010 and every resident of the home as specified in the plan.

Grounds / Motifs :

1.) An identified resident's plan of care related to nutrition indicated that staff would make a referral to the Registered Dietitian if less than required meal was consumed or if fluid intake was less than required for three consecutive days.

A review of the resident's clinical health record and confirmation from the Registered Dietitian indicated that the identified resident had a daily fluid requirement.

A review of the resident's fluid records indicated that the resident consumed less than the daily requirement.

The Registered Dietitian confirmed that they did not receive a nutrition referral to assess the resident's hydration and would expect a referral for this resident since fluid intakes were consistently below the requirements.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident. (165)

2.) The plan of care for an identified resident indicated that one staff member was to provide assistance with Activities of daily living when the identified resident was showing signs of fatigue.

The plan of care further indicated different interventions.

On identified date the resident was observed as tired and the assistance was not provided as per plan of care.

Interview with two Personal Support Workers confirmed that the resident was fatigued, the assistance was not provided and the intervention were not offered and the care set out in the plan of care was not provided to the resident as specified in the plan.
(165)

3. An identified resident was noted to have physical limitations.

Upon review of the Physician Orders it was noted that there was an order for a specified intervention.

Record review revealed that the specified interventions were noted in the plan of care.

Upon two separate observations, it was noted that the interventions were not in place as per plan of care.

Upon interview with a Personal Support Worker, it was confirmed that the resident did not have the identified interventions and care set out in the plan of care was not provided to the identified resident as specified in the plan. (519)

4. The plan of care for an identified resident indicated that an identified assistive device was to be used.

The Resident was observed with an Assistant Director of Care (ADOC) in attendance, to have the wrong number of assistive devices in place.

The ADOC confirmed that only one of the assistive devices was to be used at the time of observation.

The licensee failed to ensure that care was provided for an identified resident as specified in the plan of care.
(192)

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

Aug 03, 2015(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Order / Ordre :

The licensee must ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident's plan of care.

On two different occasions an identified resident was observed to have an assistive device in place and this was confirmed by a Personal Support Worker responsible for providing the resident care.

A review of the clinical health record indicated that the use of the assistive device was not included in the resident's plan of care.

The Registered Nurse confirmed that the use of the assistive device was not included in the resident's plan of care, that a physician/registered nurse in the extended class had not ordered or approved the assistive device and that the consent by the substitute decision-maker of the resident had not been attained.

The licensee has failed to ensure that a resident may be restrained by a physical device if the restraining of the resident was included in the resident's plan of care. (165)

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

Aug 03, 2015(A1)

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 :

The licensee must ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment for Resident #001, #004 and #017 and all other residents assessed to require bed rails.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A bed evaluation was completed in the home in March 2014 and beds were identified to have failed entrapment testing in zones 2, 3, and 4. Changes were made to the beds including the addition of new mattress surfaces and the removal of some bed rails.

Interview with an Associate Director of Care confirmed that there was no record of reassessment when changes to beds were made following the March 2014 assessment.

A bed survey conducted by the home identified that 66 of 156 (42%) beds in the home have bed rails attached. The document does not identify the zones entrapment or whether the beds achieved a pass or fail for in testing for entrapment.

Interview with the Executive Director identified that this list was just being initiated and did not include re-evaluation of all bed systems.

Interview with the person initiating the list confirmed that the identified record was the most up to date list, including changes made to beds since the March 2014 evaluation and confirmed that zones of assessment had not been assessed using the recommended tool.

Interview with the ADOC identified that they had not received training on the assessment of beds for entrapment.

The home's policy titled Resident Bed System/Entrapment, indicated that all bed systems were to be evaluated annually, at a minimum, for zones of entrapment.

Observation of the bed occupied by an identified resident identified that both bed rails were in the raised position. The mattress was noted to move readily with light pressure laterally and a potential entrapment risk was evident at the distal end of the bed rail. The assessment of the bed used by the resident identified that only one rail was in use.

Observation of the bed occupied by an identified resident identified use of two quarter rails in the up position. Observation confirmed by an ADOC identified that the bed rail on the resident's right side was loose fitting and presented a potential entrapment hazard for the resident.

Observation of the bed occupied by an identified resident during stage one and two of this inspection that the mattress moved laterally on the bed frame allowing a gap greater than six inches between the mattress and the end of the bed rail. No mattress stoppers were observed and a gap of four inches was observed at the foot of the bed when the mattress was pushed to the top of the frame. Review of the entrapment checklist completed indicated that mattress stoppers were in place and that the mattress covered the entire length and width of the bed frame.

The licensee failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. (192)

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

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

Aug 03, 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

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
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

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

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 30 day of March 2015 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : NUZHAT UDDIN - (A1)

Service Area Office /
Bureau régional de services : London