Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 30, 2017	2017_600568_0003	003969-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

DOROTHY GINTHER (568), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 23, 24, 28, 2017 and March 1, 2, 2017

During the course of the inspection, the inspector(s) spoke with the Regional Director of Operations, Executive Director, Acting Director of Care, two Clinical Leads, a Registered Dietitian, three Registered Nurses, two Registered Practical Nurses, and seven Personal Support Workers.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **2 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 #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were free from neglect by the licensee or staff in the home.

O.Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) 2856-000003-17 was submitted by the home related to the unexpected death of a resident. According to the CI description a registered staff was alerted by a Personal Support Worker (PSW) that a resident was in distress. According to the CI description the registered staff observed the resident and told the PSW they were fine. Several other staff heard this same report by the registered staff. The PSW then left the resident in the area of the nursing station because they were still exhibiting signs of distress. The registered staff stated during an interview conducted by the home that they undertook no assessment or interventions with respect to the identified resident. When it was nearing shift change, an oncoming registered staff was concerned about the identified resident based on initial observations and proceeded to take vitals and call the physician. The resident was found deceased by a PSW less than two hours later.

During interviews with several Personal Support Workers (PSW), they shared that when the identified resident exhibited signs of distress, it was reported to the registered staff however, no assessments or interventions were observed to be completed by registered staff during this time. One PSW also shared that the resident had a similar incident several months previous where the resident exhibited similar signs and symptoms of distress, and after reporting this to registered staff treatment had been provided.

During an interview with a registered staff, they stated that when they arrived on the home area just before their shift they noticed two registered staff standing by the nursing office and in front of a resident. As they approached the staff they could see that the resident was in distress. The resident was very pale and it looked like their hands and face were mottled. The registered staff leaving their shift advised the oncoming registered staff that the resident had been like that for the last twenty minutes. The registered staff leaving shift stated that they had not assessed the resident or taken vitals. Immediately, the oncoming registered staff said that they began checking the residents vitals and asked the other registered staff to call the family. The resident's oxygen saturation and core temperature were low. The oncoming registered staff then asked a PSW to put the resident to bed with the head of the bed elevated and to make the resident comfortable. They asked the registered staff leaving shift to call the family while they contacted the doctor. During report, the registered staff leaving shift did not

mention that anything unusual had transpired that day with respect to the identified resident.

A registered staff told inspectors that they were working on another home area and they went over to another home area to do a medication count with the registered staff working on that unit. While walking to the medication room with the registered staff, they observed a resident sitting in the area of the nurses station. The resident seemed to be in some distress and when they asked the registered staff what was wrong they said they were encouraging them to cough. Both staff then went into the medication room and shut the door while they did their count. When they came out of the room maybe five minutes later they noted that the resident's color was not good. The registered staff from that home area said to the visiting registered staff that they were concerned about the resident's oxygen level. They said they had not yet checked their oxygen saturation. While they were speaking with the visiting registered staff, a third registered staff coming in for the next shift arrived. They quickly took over the situation at which point the visiting registered staff returned to their home area.

During an interview with the registered staff covering the home area at the time of the identified incident, they told inspectors that a PSW had alerted them that one of the resident's was in distress. The registered staff said they were not worried as the resident's presentation was fairly normal. The registered staff said they briefly looked at the resident and told the PSW that the resident was fine. The registered staff said they asked a PSW to put the resident near the nurses station where they could monitor them between treatments. The staff member said that the resident's color remained good and they were encouraging them to cough. When asked if the registered staff had assessed the resident or taken their vitals they replied that they had not. They said that after doing their medication count with with another registered staff they came out of the medication room and noted that the resident's color had changed. The registered staff said that they were about to take the resident's vitals including oxygen saturation when the registered staff from the oncoming shift appeared. The asked the oncoming registered staff to take vitals and told them they would call the family. They also asked staff to put the resident to bed as family was coming in. When asked if the registered staff had communicated with the oncoming registered staff their concerns surrounding the incident, they could not recall.

The identified resident's plan of care identified that the resident was a high risk related to a specific concern. Progress notes identified a previous incident however, there was no documentation of a referral to an identified staff member and no documented

assessments completed for the resident in the last 18 months related to this concern.

During an interview with an identified staff member they shared that it was their practice to document assessments of observations in the progress notes. The staff member said they were not made aware of the resident's previous incident, and had not received a referral to assess the resident with respect to the identified concern. As part of the annual evaluation the staff member thought they had observed the resident, but they acknowledged that there was no documentation regarding observations in the annual assessment.

During an interview with the Regional Director of Operations and the Executive Director they acknowledged that despite documentation of concerns and a previous incident there had been no recent referral to the identified staff member. In addition, the registered staff on duty when the identified incident occurred was notified of that the resident was in distress, but failed to properly assess and monitor the resident to ensure their safety and well-being. This inaction may have contributed to the resident's death.

The severity was determined to be a level three as there was actual harm or risk of harm. The scope of this issue was identified as being isolated during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy under the section entitled "Resident Non-Abuse" Index ADMIN1-P10-ENT reviewed July 31, 2016 and effective August 31, 2016, description "Resident Non-Abuse Program" stated under the heading "STANDARD" that all persons involved with Revera Homes have a duty to report any form of alleged, potential, suspected or witnessed abuse or neglect, including suspected abuse or neglect outside of the Home. Anyone who becomes aware of,or, suspects abuse or neglect of a Resident, must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift.

Review of the home's Non-Abuse Training spreadsheet for 2016 identified that 100 per cent of staff had completed the annual training. During an interview with the home's 2016 Education Lead they shared that as part of the non-abuse training they review the home's policy and the staff's duty to immediately report any incidents of alleged, suspected or witnessed abuse or neglect. The Education Lead said that staff were directed to report to their immediate supervisor.

A Critical Incident (CI) 2856-000003-17 was submitted by the home related to the unexpected death of a resident. According to the CI description a registered staff was alerted by a Personal Support Worker (PSW) that a resident was in distress. The registered staff observed the resident and told the PSW they were fine. Several other staff heard this same report by the registered staff. The PSW then left the resident in the area of the nursing station because they were still exhibiting signs of distress. The registered staff stated during an interview conducted by the home that they undertook no assessment or interventions with respect to the identified resident. When it was nearing shift change, an oncoming registered staff was concerned about the identified resident based on initial observations and proceeded to take vitals and call the physician. The resident was found deceased by a PSW less than two hours later.

During interviews with three Personal Support Workers (PSW) they told inspectors that they received training regarding the home's policy related to the prevention of abuse and neglect of residents prior to starting work in the home and annually there after. The staff said that if they suspected abuse or neglect of a resident they would first ensure the resident's safety and then report the incident to the registered staff on their home area. A PSW told inspectors about an incident where a resident was in distress. They immediately notified the registered staff on duty who came over and told the PSW that

the resident was fine. Two other PSW's observed the resident in distress and saw the registered staff go over to the resident's table and tell the PSW that the resident was fine. The PSW stated that the registered staff did not conduct any assessment of the resident, nor did they intervene in any way to assist the resident while they were in distress. They asked another PSW to put the resident outside the nursing office so that the registered staff could monitor the resident as they remained concerned. The registered staff told the PSW they would be in the office with the door closed. Later that shift the Personal Support Workers said they were told that the resident had died. When two of the PSW's were asked if they were concerned about the care the identified resident received, they both said they felt the registered staff should have done something to help the resident when they were in distress. They were concerned that the staff members inaction had contributed to the resident's death. When asked if they had reported their concerns to anyone, one of the PSW's said that they mentioned something to a registered staff working in another home area later that shift. The other PSW told the inspector that they had not reported because they felt that "the nurse knows everything".

During an interview with a registered staff they told the inspector that as part of their annual education they received training on the prevention of abuse and neglect. The education included mandatory reporting of any alleged or suspected incidents of abuse or neglect. The staff member said that they were told to immediately report any incidents to the on-call manager. The registered staff said that when they overheard staff say that another registered staff had not responded to a resident when they were in distress they became suspicious. They were concerned that the staff member's inaction may have contributed to their death. The registered staff said that as soon as they had time during their shift they sent an email to the acting Director of Care in which they said that they would like to speak with them about some issues concerning a specific resident's death and a specific staff member. In this email they asked the acting DOC to give them a call or to arrange a time to meet and stated that it was important. The registered staff said that they received an email response the next day from the acting DOC which said that because of their schedule they would not be able to meet with them for a couple of days. According to the registered staff it was not until three days later that the acting DOC called the registered staff. At that point the staff member told the acting DOC about their concern that another registered staff may not have taken appropriate actions prior to the identified resident's death. The registered staff acknowledged that they should have tried to speak with the acting Director of Care sooner or sought out another manager given their suspicions.

During an interview with the acting Director of Care they acknowledged having received an email from a registered staff which asked the acting DOC to give them a call regarding a concern about a resident's death and a specific staff member. The acting DOC said that they answered the email right away and asked the staff if they could touch base a couple of days later. When they did not hear back they assumed that was fine. The Acting DOC said that because of other commitments it was not until three days later that they had time to call the registered staff. At that point the registered staff shared that they heard staff discussing the identified resident's death and their concerns that a registered staff's inaction may have contributed to their death. Because it was late in the day and the staff involved in the alleged incident were not working the acting DOC decided to go home and deal with the situation in the morning. The following morning they commenced an investigation into the alleged incident of neglect and notified their acting Executive Director of the concerns. After doing a preliminary investigation the acting DOC submitted a Critical Incident Report late that same day.

During an interview with the Executive Director and Regional Director of Operations they reviewed the home's policy with respect to Resident Non-Abuse with the Inspectors. They said that it was the home's expectation that all staff receive education regarding their Resident Non-Abuse policies prior to starting work at the home and on an annual basis. This education included a review of the different types of abuse and neglect and the need for reporting all incidents of alleged or suspect abuse / neglect immediately. When asked who the staff should report to, the Regional Director of Operations said that the Personal Support Workers should report to the registered staff on their unit and the registered staff would report to a Clinical Lead or Manager. On evenings and nights the registered staff would contact the on-call staff and depending on the situation they would alert the Executive Director or Director of Care. The Regional Director of Operations acknowledged that the policy, ADMIN1-P10-ENT Resident Non-Abuse Program, specific to reporting did not agree with the reporting process that they just outlined and the home's education program. The policy stated that all staff were to report any alleged, suspected or witnessed incidents of abuse or neglect to the Executive Director, or if unavailable, to the most senior supervisor on shift. The Regional Director of Operations and ED acknowledged that with the situation involving the identified resident staff at a number of levels including Personal Support Workers, registered staff and the acting Director of Care, did not immediately report their suspicions of neglect and thus they did not implement the home's policy that promotes zero tolerance of abuse and neglect of residents.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as widespread during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 20. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

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 registered dietitian, who was a member of the staff of the home, assessed any risks related to nutrition and hydration care.

Personal Support Workers (PSW) interviewed told the Inspectors that the identified resident had a history related to a specific concern, and exhibited a specific symptom often. The PSW said that the resident had a prior episode of distress and the resident was administered treatment.

The registered staff told the Inspectors that the resident exhibited specific symptoms while completing a specific task and this was normal for the resident.

A Clinical Lead told the Inspectors that the resident had a history related to a particular concern and exhibited a specific symptom often. They recalled one occasion where the resident had to be administered treatment.

Review of the clinical record for the resident identified the following:
- A nursing progress note which stated that a PSW reported that the resident was in distress. The resident was assessed by a registered staff and the plan was to monitor and report to the night RN.
- No documented assessments by the home's Registered Dietitian (RD) in the last 18 months.
- No referrals to the RD for the specific concern in the last 18 months.
- The annual nutritional assessment did not include further assessment of the particular concern identified.

During an interview with the RD they told the Inspectors that their practice was to document assessments of observations in the progress notes. The RD said they did not use a specific assessment form to document assessments related to a particular concern. The RD said that they had not received a referral to assess the resident's identfied concern despite the documented incident that previously occurred. The RD said they were not aware of this incident. In addition, the RD said that they thought they had observed the resident when they did their last annual evaluation, but they acknowledged that there was no documentation regarding observations in the annual assessment.

The home's identified policy with an effective date of August 31, 2016, stated that the RD may utilize a specific tool for assessments related to this particular concern. Review of this policy found that it did not provide further direction for documentation of assessments if this tool was not used by the RD. [s. 26. (4) (a),s. 26. (4) (b)]

2. During an observation, Inspector #630 observed a resident exhibiting a specific symptom while completing a particular task.

A PSW and RPN acknowledged that the resident exhibited this symptom while performing a specific task. The RPN acknowledged that the identified symptom was a sign of particular concern.

During a review of the identified resident's clinical record the following was noted:
- No documented assessments by the home's Registered Dietitian (RD) in 2016 or 2017 related to the identified concern.
- No referrals to the RD in 2016 or 2017 related to the concern.
- The annual nutritional assessment completed by the RD did not included further assessment of the identified concern.

The RD told the Inspectors that they had not received nutritional referrals for the identified resident related to the specific concern. The RD said they thought they had recently observed the resident as part of the annual assessment but acknowledged there was no documentation to indicate this. The RD said they had not completed any assessments for the resident as staff had not notified them of any concerns. [s. 26. (4) (a),s. 26. (4) (b)]

3. The RD told the Inspectors they had recently received a referral to assess an identified resident with respect to a specific concern as the resident had demonstrated particular symptoms. The RD said they had documented their assessment related to this concern in the progress notes.

Review of the clinical record for the identified resident showed the resident had a history of the identified concern which had not been assessed by the home's RD. The clinical record included the following documentation:
- A nursing progress which stated the resident had a particular incident which required intervention by staff.
- A progress note by the RD which stated that a nutrition care referral had been received for a specific concern and one intervention to address the concern had been identified.
- A nursing progress note which stated a PSW reported the resident had difficulty and exhibited symptoms related to a particular concern.
- No other documented RD assessments related to the particular concern were observed for the period when the resident was documented as having concerns.

Further review of the clinical record for the resident identified a second incident for which the RD received a nutrition care referral. The RD conducted an observation but did not document an assessment in response to the identified referral. No other assessment note or documentation was noted.

The RD told the Inspectors that they had developed their own process for assessment of the particular concern. They were documenting their findings in a progress note in the resident's electronic chart. The RD said it was their habit to document what was noticed versus using the specified tool. Inspectors reviewed the assessment notes in Point Click Care (PCC) with the RD and they acknowledged that their documentation did not capture the components of an assessment for this particular concern. [s. 26. (4) (a),s. 26. (4) (b)]

4. During an observation an identified resident exhibited symptoms of a particular

concern.

Review of the clinical record for the resident showed they had a history related to this concern. The clinical record included a number of referrals related to this particular concern but there were no specific assessment notes or documentation related to this concern.

Inspectors reviewed the documentation for the identified resident with the RD and it was acknowledged that there was no documentation of an assessment.

The Regional Director of Operations (RDO) told the Inspectors that it was the home's expectation that if the RD was not using the specific tool, then their assessment should be documented based on this tool and using the professional practice standards of the RD. One line in a progress note would not constitute an assessment. The Regional Director of Operations acknowledged that the identified residents that had a history of the identified concern should have had a specific assessment completed by the RD. The RDO further stated that it was the home's expectation that resident's assessed as being at risk related to nutrition and hydration care were to be assessed by the RD.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as widespread during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated including neglect of a resident by a licensee or staff.

A Critical Incident (CI) 2856-000003-17 was submitted by the home related to the unexpected death of a resident.

The acting Director of Care (DOC) told inspectors that they received an email approximately 36 hours after the incident, from a registered staff asking if they could speak with the DOC about some issues concerning the identified resident's death. It was not until a further two days later that the acting DOC said they called the registered staff to discuss their concerns. According to the acting DOC, the registered staff told them that they overheard staff talking about the incident and some of them were concerned that the nurse that had been in charge may be responsible because they had not taken action when the resident was identified as being in distress. The registered staff provided the acting DOC with the names of the PSW's that were involved. The registered staff also told the acting DOC that the nurse had not shared any of what happened prior to them starting their shift with regards to the identified resident. After speaking with registered staff, the acting DOC said that they looked at the schedule and noted that neither the nurse or the identified PSW's that were involved with the incident were working at the time, so they decided that any follow-up could wait until the next morning. The next morning, the acting DOC said they began the investigation into the

incident and advised the acting Executive Director.

Review of the investigation notes for the critical incident (CI) identified that the investigation did not commence until five days after the incident. The acting Director of Care told the inspectors that they were first advised of a concern regarding the resident's death four days earlier via email. However, it was not until the evening before the CI was submitted that they were made fully aware of the suspicion of abuse/neglect after they spoke with registered staff. The acting DOC acknowledged that they did not immediately commence an investigation into the suspected incident of neglect involving the identified resident.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on March 5, 2014, as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection 2014_259520_0010. [s. 23. (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 every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated including neglect of a resident by a licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition Care and Hydration Programs included the implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and hydration and the implementation of interventions to mitigate and manage risks related to nutrition care and hydration.

The RDO reported that over the past year the corporation had revised many of their policies and often the revisions were related to formatting versus content. The RDO said that a specific policy effective August 31, 2016, would have replaced a previous policy and it was the expectation that staff would be aware of the policy. The RDO said that at the time of the inspection they were implementing a new process for policy review whereby all staff were required to sign off that they had reviewed and read new policies.

The home's policy related to the identified concern was effective August 31, 2016 and outlined the following:
- In the "Referral and Assessment" section it stated that the RD may utilize the specific assessment tool. The policy did not include direction for RDs regarding assessment and

documentation of assessment if this tool was not being used.
-In the Referral and Assessment" section it also stated that the specific tool may be completed by the Nurse for all Residents that display new or worsening signs and symptoms related to the concern.
- The introduction to the specified program stated that one of the goals of the program was utilization of a standard assessment form to ensure consistent assessment.
- In the "Interventions" section it stated that members of the Interdisciplinary Team would provide regular monitoring, follow-up and assessment. Referral would be sent to the appropriate discipline as required.
- In the "Interventions" section it also stated that any incidents were to be documented and a referral sent to the RD/Occupational Therapist (OT) for assessment.

A Clinical Lead told inspectors that they had been responsible for staff education in the home for 2016 until January 2017. They stated that they were not familiar with the identified policy effective August 31, 2016 and had not reviewed this policy with staff during their mandatory education.

During an interview with the RD they shared with inspectors that they had not received a referral to assess the resident for the identified concern prior to the incident described in CI 2856-000003-17. The RD said the registered staff in the home used the electronic referral forms in Point Click Care (PCC) to alert them about the identified concern but the staff did not use the specified tool. The RD told the Inspectors that they had developed their own process for the documentation of these assessments. They would document their assessment findings in a progress note within the electronic record. The RD said it was their habit to document what was noticed versus using the "specified assessment tool. While they were aware of the assessment tool as they worked in another home and used this as a reference they did not document using the form. The RD acknowledged that the documentation in PCC of their observations and assessments did not reflect all components of the assessment or observations that had been made regarding resident's identified concern. The RD said that at the time of the inspection they were not aware of and had not been educated on the identified policy which had an effective date of August 31, 2016. The RD said they had received notification about two weeks prior to the inspection that they were to review and sign off on any new policies but they were not sure if the policy was part of that review.

The Regional Director of Operations (RDO) told Inspectors that it was the expectation in the home that staff would implement and follow the policies and procedures in place regarding the identified concern as part of the Nutrition and Hydration Care Program.

The licensee failed to ensure that the Nutrition and Hydration programs included implementation, in consultation with the registered dietitian, of the identified policy and implementation of interventions to mitigate and manage risk related to nutrition care and hydration.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as a pattern during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 68. (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 the Nutrition Care and Hydration programs included the implementation, in consultation with a registered dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and hydration and the implementation of interventions to mitigate and manage risks related to nutrition care and hydration, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
2. Neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A Critical Incident (CI) 2856-000003-17 was submitted by the home related to the unexpected death of a resident.

When Personal Support Workers were asked if they were concerned about the care the resident received prior to their death, they said that they felt the registered staff should have done something to help the resident when they were in distress. The PSW's also stated that they were concerned that the staff members inaction may have contributed to the resident's death. When asked if they had reported their concerns to anyone, one of the PSW's said that they mentioned something to another registered staff. A second PSW told the inspector that they had not reported because they felt that "the nurse knows everything".

When asked if any of the staff had expressed a concern about the way the resident had been cared for prior to their death, the registered staff said that a PSW had spoken with them. They were very upset and said that they had asked the registered staff to monitor the resident. The registered staff could not recall if the PSW had shared anything about

the resident being in distress at that time. The registered staff said that they had not reported this conversation as they did not have a clear idea of what happened and did not want to build things on suspicion.

During an interview with the oncoming registered staff, they told inspectors that they were not aware that the resident had been in distress. The registered staff was not aware that the PSW's had asked the registered staff on duty at the time to monitor the resident because they were concerned about their condition. When they had shift report with the registered staff there was nothing mentioned about the resident in terms of an incident that day. During their shift the following day, the registered staff said that they overheard several Personal Support Workers talking about the identified resident's death. They said that they had heard from the staff working that the resident had been in distress and the nurse had not done anything. When the registered staff heard this information they were concerned that this may have contributed to the resident's death. That night they sent an email to the acting Director of Care in which they told them they would like to speak with them about some issues concerning the identified resident's death and the registered staff on duty at the time. They asked if the acting DOC could give them a call or arrange a time to meet. The staff member stated in the email that it was important. The registered staff said they received an email response the next day which said that they would have to touch base in a couple of days because of their schedule. It was not until four days after the registered staff sent the initial email that the acting DOC called them. At that point, the registered staff shared the concerns expressed by staff that a colleague's inactions may have contributed to the resident's death.

Review of the investigation notes for the CI 2856-0000030-17 included a copy of the email sent by the registered staff to the acting DOC the day after the incident. An email response later the same day from the acting DOC said, OK, they would have to touch base in a couple of days because of their work schedule.

During an interview with the acting Director of Care, they acknowledged that they had received an email from a registered staff regarding their concerns about a resident's death and the nurse working at the time. The acting DOC said they asked the staff if they could touch base in a couple of days as they would not be in the office much before that time. When they did not hear back they assumed that was fine. The acting DOC said that for a number of reasons they were not able to contact the registered staff until three days after they received their email. During a telephone call the registered staff told the acting DOC what they had heard. Because it was late in the day and the staff involved in the alleged incident were not working the acting DOC decided to go home

and deal with the situation in the morning. The next morning they commenced their investigation into the incident and notified their acting Executive Director of the situation. Late that day they notified the Director by submitting a Critical Incident Report. The acting DOC said that staff were expected to immediately notify the on-call manager when they suspected or witnessed abuse or neglect. The on-call manager would then notify either the Executive Director or the DOC and they would report to the Director. The acting DOC said that although registered staff eluded to a problem in their email it was not until they spoke with them three days later that they were made fully aware of the situation and potential neglect of the identified resident. The acting DOC acknowledged that they should have called the staff back immediately when the concern was brought to their attention. Once they were made aware of the suspected neglect they should have immediately reported the concern to the Director.

During an interview with the Executive Director and Regional Director of Operations, they told inspectors that it was the home's expectation that all staff immediately report any suspicions of resident abuse or neglect. If there were reasonable grounds to suspect abuse or neglect that may have resulted in harm or risk of harm then the home should immediately report these suspicions to the Director via a Critical Incident. The Regional Director of Operations acknowledged that staff in the home, including Personal Support Workers, registered staff and the acting Director of Care, had reasonable grounds to suspect that the identified resident was neglected and that this may have contributed to their death. They failed to immediately report their suspicion and the information upon which it was based to the Director.

The severity was determined to be a level one as there was minimal risk of harm. The scope of this issue was identified as isolated during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. [s. 24. (1)]

Issued on this 13th day of July, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), AMIE GIBBS-WARD (630)
Inspection No. / No de l'inspection :	2017_600568_0003
Log No. / Registre no:	003969-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 30, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	COLUMBIA FOREST 650 MOUNTAIN MAPLE AVENUE, WATERLOO, ON, N2V-2P7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall protect residents from neglect by staff. The licensee shall ensure that changes in a resident's condition including concerns related to swallowing and/or choking are assessed, communicated to staff, documented, and that there is a process in place to ensure the resident is monitored, reassessed and interventions are in place to address the concerns.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were free from neglect by the licensee or staff in the home.

O.Reg 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A Critical Incident (CI) 2856-000003-17 was submitted by the home related to the unexpected death of a resident. According to the CI description a registered staff was alerted by a Personal Support Worker (PSW) that a resident was in distress. According to the CI description the registered staff observed the resident and told the PSW they were fine. Several other staff heard this same report by the registered staff. The PSW then left the resident in the area of the nursing station because they were still exhibiting signs of distress. The registered staff stated during an interview conducted by the home that they undertook no assessment or interventions with respect to the identified resident. When it was nearing shift change, an oncoming registered staff was concerned about the identified resident based on initial observations and proceeded to take vitals and call the physician. The resident was found deceased by a PSW less

than two hours later.

During interviews with several Personal Support Workers (PSW), they shared that when the identified resident exhibited signs of distress, it was reported to the registered staff however, no assessments or interventions were observed to be completed by registered staff during this time. One PSW also shared that the resident had a similar incident several months previous where the resident exhibited similar signs and symptoms of distress, and after reporting this to registered staff treatment had been provided.

During an interview with a registered staff, they stated that when they arrived on the home area just before their shift they noticed two registered staff standing by the nursing office and in front of a resident. As they approached the staff they could see that the resident was in distress. The resident was very pale and it looked like their hands and face were mottled. The registered staff leaving their shift advised the oncoming registered staff that the resident had been like that for the last twenty minutes. The registered staff leaving shift stated that they had not assessed the resident or taken vitals. Immediately, the oncoming registered staff said that they began checking the resident's vitals and asked the other registered staff to call the family. The resident's oxygen saturation and core temperature were low. The oncoming registered staff then asked a PSW to put the resident to bed with the head of the bed elevated and to make the resident comfortable. They asked the registered staff leaving shift to call the family while they contacted the doctor. During report, the registered staff leaving shift did not mention that anything unusual had transpired that day with respect to the identified resident.

A registered staff told inspectors that they were working on another home area and they went over to another home area to do a medication count with the registered staff working on that unit. While walking to the medication room with the registered staff, they observed a resident sitting in the area of the nurses' station. The resident seemed to be in some distress and when they asked the registered staff what was wrong they said they were encouraging them to cough. Both staff then went into the medication room and shut the door while they did their count. When they came out of the room maybe five minutes later they noted that the resident's color was not good. The registered staff from that home area said to the visiting registered staff that they were concerned about the resident's oxygen level. They said they had not yet checked their oxygen saturation. While they were speaking with the visiting registered staff, a third

registered staff coming in for the next shift arrived. They quickly took over the situation at which point the visiting registered staff returned to their home area.

During an interview with the registered staff covering the home area at the time of the identified incident, they told inspectors that a PSW had alerted them that one of the resident's was in distress. The registered staff said they were not worried as the resident's presentation was fairly normal. The registered staff said they briefly looked at the resident and told the PSW that the resident was fine. The registered staff said they asked a PSW to put the resident near the nurses' station where they could monitor them between treatments. The staff member said that the resident's color remained good and they were encouraging them to cough. When asked if the registered staff had assessed the resident or taken their vitals they replied that they had not. They said that after doing their medication count with with another registered staff they came out of the medication room and noted that the resident's color had changed. The registered staff said that they were about to take the resident's vitals including oxygen saturation when the registered staff from the oncoming shift appeared. The asked the oncoming registered staff to take vitals and told them they would call the family. They also asked staff to put the resident to bed as family was coming in. When asked if the registered staff had communicated with the oncoming registered staff their concerns surrounding the incident, they could not recall.

The identified resident's plan of care identified that the resident was a high risk related to a specific concern. Progress notes identified a previous incident however, there was no documentation of a referral to an identified staff member and no documented assessments completed for the resident in the last 18 months related to this concern.

During an interview with an identified staff member they shared that it was their practice to document assessments of observations in the progress notes. The staff member said they were not made aware of the resident's previous incident, and had not received a referral to assess the resident with respect to the identified concern. As part of the annual evaluation the staff member thought they had observed the resident, but they acknowledged that there was no documentation regarding observations in the annual assessment.

During an interview with the Regional Director of Operations and the Executive Director they acknowledged that despite documentation of concerns and a

previous incident there had been no recent referral to the identified staff member. In addition, the registered staff on duty when the identified incident occurred was notified of that the resident was in distress, but failed to properly assess and monitor the resident to ensure their safety and well-being. This inaction may have contributed to the resident's death.

The severity was determined to be a level three as there was actual harm or risk of harm. The scope of this issue was identified as being isolated during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations.
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 01, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee shall ensure that the written policy to promote zero tolerance of abuse and neglect of residents includes the following:

i) Clear direction for all staff as to the process for reporting any alleged, suspected or witnessed incidents of abuse or neglect;
ii) Who each staff member should report to and any variations taking into consideration time of day, weekends and holidays;

The licensee shall ensure that all staff are educated with respect to the policy to promote zero tolerance of abuse and neglect, specifically the process for reporting, and that the policy is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with.

The home's policy under the section entitled "Resident Non-Abuse" Index ADMIN1-P10-ENT reviewed July 31, 2016 and effective August 31, 2016, description "Resident Non-Abuse Program" stated under the heading "STANDARD" that all persons involved with Revera Homes have a duty to report any form of alleged, potential, suspected or witnessed abuse or neglect, including suspected abuse or neglect outside of the Home. Anyone who becomes aware of, or, suspects abuse or neglect of a Resident, must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift.

Review of the home's Non-Abuse Training spreadsheet for 2016 identified that 100 per cent of staff had completed the annual training. During an interview with the home's 2016 Education Lead they shared that as part of the non-abuse training they review the home's policy and the staff's duty to immediately report any incidents of alleged, suspected or witnessed abuse or neglect. The Education Lead said that staff were directed to report to their immediate supervisor.

A Critical Incident (CI) 2856-000003-17 was submitted by the home related to the unexpected death of a resident. According to the CI description a registered staff was alerted by a Personal Support Worker (PSW) that a resident was in distress. The registered staff observed the resident and told the PSW they were fine. Several other staff heard this same report by the registered staff. The PSW then left the resident in the area of the nursing station because they were still exhibiting signs of distress. The registered staff stated during an interview conducted by the home that they undertook no assessment or interventions with respect to the identified resident. When it was nearing shift change, an oncoming registered staff was concerned about the identified resident based on initial observations and proceeded to take vitals and call the physician. The resident was found deceased by a PSW less than two hours later.

During interviews with three Personal Support Workers (PSW) they told inspectors that they received training regarding the home's policy related to the prevention of abuse and neglect of residents prior to starting work in the home and annually thereafter. The staff said that if they suspected abuse or neglect of a resident they would first ensure the resident's safety and then report the incident to the registered staff on their home area. A PSW told inspectors about an incident where a resident was in distress. They immediately notified the registered staff on duty who came over and told the PSW that the resident was fine. Two other PSW's observed the resident in distress and saw the registered staff go over to the resident's table and tell the PSW that the resident was fine. The PSW stated that the registered staff did not conduct any assessment of the resident, nor did they intervene in any way to assist the resident while they were in distress. They asked another PSW to put the resident outside the nursing office so that the registered staff could monitor the resident as they remained concerned. The registered staff told the PSW they would be in the office with the door closed. Later that shift the Personal Support Workers said they were told that the resident had died. When two of the PSW's were asked if they were

concerned about the care the identified resident received, they both said they felt the registered staff should have done something to help the resident when they were in distress. They were concerned that the staff members' inaction had contributed to the resident's death. When asked if they had reported their concerns to anyone, one of the PSW's said that they mentioned something to a registered staff working in another home area later that shift. The other PSW told the inspector that they had not reported because they felt that "the nurse knows everything".

During an interview with a registered staff they told the inspector that as part of their annual education they received training on the prevention of abuse and neglect. The education included mandatory reporting of any alleged or suspected incidents of abuse or neglect. The staff member said that they were told to immediately report any incidents to the on-call manager. The registered staff said that when they overheard staff say that another registered staff had not responded to a resident when they were in distress they became suspicious. They were concerned that the staff member's inaction may have contributed to their death. The registered staff said that as soon as they had time during their shift they sent an email to the acting Director of Care in which they said that they would like to speak with them about some issues concerning a specific resident's death and a specific staff member. In this email they asked the acting DOC to give them a call or to arrange a time to meet and stated that it was important. The registered staff said that they received an email response the next day from the acting DOC which said that because of their schedule they would not be able to meet with them for a couple of days. According to the registered staff it was not until three days later that the acting DOC called the registered staff. At that point the staff member told the acting DOC about their concern that another registered staff may not have taken appropriate actions prior to the identified resident's death. The registered staff acknowledged that they should have tried to speak with the acting Director of Care sooner or sought out another manager given their suspicions.

During an interview with the acting Director of Care they acknowledged having received an email from a registered staff which asked the acting DOC to give them a call regarding a concern about a resident's death and a specific staff member. The acting DOC said that they answered the email right away and asked the staff if they could touch base a couple of days later. When they did not hear back they assumed that was fine. The Acting DOC said that because of other commitments it was not until three days later that they had time to call the

registered staff. At that point the registered staff shared that they heard staff discussing the identified resident's death and their concerns that a registered staff's inaction may have contributed to their death. Because it was late in the day and the staff involved in the alleged incident were not working the acting DOC decided to go home and deal with the situation in the morning. The following morning they commenced an investigation into the alleged incident of neglect and notified their acting Executive Director of the concerns. After doing a preliminary investigation the acting DOC submitted a Critical Incident Report late that same day.

During an interview with the Executive Director and Regional Director of Operations they reviewed the home's policy with respect to Resident Non-Abuse with the Inspectors. They said that it was the home's expectation that all staff receive education regarding their Resident Non-Abuse policies prior to starting work at the home and on an annual basis. This education included a review of the different types of abuse and neglect and the need for reporting all incidents of alleged or suspect abuse / neglect immediately. When asked who the staff should report to, the Regional Director of Operations said that the Personal Support Workers should report to the registered staff on their unit and the registered staff would report to a Clinical Lead or Manager. On evenings and nights the registered staff would contact the on-call staff and depending on the situation they would alert the Executive Director or Director of Care. The Regional Director of Operations acknowledged that the policy, ADMIN1-P10-ENT Resident Non-Abuse Program, specific to reporting did not agree with the reporting process that they just outlined and the home's education program. The policy stated that all staff were to report any alleged, suspected or witnessed incidents of abuse or neglect to the Executive Director, or if unavailable, to the most senior supervisor on shift. The Regional Director of Operations and ED acknowledged that with the situation involving the identified resident staff at a number of levels including Personal Support Workers, registered staff and the acting Director of Care, did not immediately report their suspicions of neglect and thus they did not implement the home's policy that promotes zero tolerance of abuse and neglect of residents.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as widespread during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2017

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall ensure that a registered dietitian, who is a member of the staff of the home, completes a nutritional assessment that includes swallowing and any other risks related to nutrition care for all residents on admission and whenever there is a significant change in a resident's health condition.

Grounds / Motifs :

1. The licensee has failed to ensure that a registered dietitian, who was a member of the staff of the home, assessed any risks related to nutrition and hydration care.

During an observation an identified resident exhibited symptoms of a particular concern.

Review of the clinical record for the resident showed they had a history related to this concern. The clinical record included a number of referrals related to this particular concern but there were no specific assessment notes or documentation related to this concern.

Inspectors reviewed the documentation for the identified resident with the RD and it was acknowledged that there was no documentation of an assessment.

The Regional Director of Operations (RDO) told the Inspectors that it was the home's expectation that if the RD was not using the specific tool, then their assessment should be documented based on this tool and using the

professional practice standards of the RD. One line in a progress note would not constitute an assessment. The Regional Director of Operations acknowledged that the identified residents that had a history of the identified concern should have had a specific assessment completed by the RD. The RDO further stated that it was the home's expectation that residents assessed as being at risk related to nutrition and hydration care were to be assessed by the RD. (630)

2. The RD told the Inspectors they had recently received a referral to assess an identified resident with respect to a specific concern as the resident had demonstrated particular symptoms. The RD said they had documented their assessment related to this concern in the progress notes.

Review of the clinical record for the identified resident showed the resident had a history of the identified concern which had not been assessed by the home's RD. The clinical record included the following documentation:
- A nursing progress which stated the resident had a particular incident which required intervention by staff.
- A progress note by the RD which stated that a nutrition care referral had been received for a specific concern and one intervention to address the concern had been identified.
- A nursing progress note which stated a PSW reported the resident had difficulty and exhibited symptoms related to a particular concern.
- No other documented RD assessments related to the particular concern were observed for the period when the resident was documented as having concerns.

Further review of the clinical record for the resident identified a second incident for which the RD received a nutrition care referral. The RD conducted an observation but did not document an assessment in response to the identified referral. No other assessment note or documentation was noted.

The RD told the Inspectors that they had developed their own process for assessment of the particular concern. They were documenting their findings in a progress note in the resident's electronic chart. The RD said it was their habit to document what was noticed versus using the specified tool. Inspectors reviewed the assessment notes in Point Click Care (PCC) with the RD and they acknowledged that their documentation did not capture the components of an assessment for this particular concern.
(630)

3. During an observation, Inspector #630 observed a resident exhibiting a specific symptom while completing a particular task.

A PSW and RPN acknowledged that the resident exhibited this symptom while performing a specific task. The RPN acknowledged that the identified symptom was a sign of particular concern.

During a review of the identified resident's clinical record the following was noted:
- No documented assessments by the home's Registered Dietitian (RD) in 2016 or 2017 related to the identified concern.
- No referrals to the RD in 2016 or 2017 related to the concern.
- The annual nutritional assessment completed by the RD did not included further assessment of the identified concern.

The RD told the Inspectors that they had not received nutritional referrals for the identified resident related to the specific concern. The RD said they thought they had recently observed the resident as part of the annual assessment but acknowledged there was no documentation to indicate this. The RD said they had not completed any assessments for the resident as staff had not notified them of any concerns. (630)

4. Personal Support Workers (PSW) interviewed told the Inspectors that the identified resident had a history related to a specific concern, and exhibited a specific symptom often. The PSW said that the resident had a prior episode of distress and the resident was administered treatment.

The registered staff told the Inspectors that the resident exhibited specific symptoms while completing a specific task and this was normal for the resident.

A Clinical Lead told the Inspectors that the resident had a history related to a particular concern and exhibited a specific symptom often. They recalled one occasion where the resident had to be administered treatment.

Review of the clinical record for the resident identified the following:
- A nursing progress note which stated that a PSW reported that the resident was in distress. The resident was assessed by a registered staff and the plan

was to monitor and report to the night RN.
- No documented assessments by the home's Registered Dietitian (RD) in the last 18 months.
- No referrals to the RD for the specific concern in the last 18 months.
- The annual nutritional assessment did not include further assessment of the particular concern identified.

During an interview with the RD they told the Inspectors that their practice was to document assessments of observations in the progress notes. The RD said they did not use a specific assessment form to document assessments related to a particular concern. The RD said that they had not received a referral to assess the resident's identified concern despite the documented incident that previously occurred. The RD said they were not aware of this incident. In addition, the RD said that they thought they had observed the resident when they did their last annual evaluation, but they acknowledged that there was no documentation regarding observations in the annual assessment.

The home's identified policy with an effective date of August 31, 2016, stated that the RD may utilize a specific tool for assessments related to this particular concern. Review of this policy found that it did not provide further direction for documentation of assessments if this tool was not used by the RD.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was identified as widespread during the course of this inspection. The home does not have a history of noncompliance in this subsection of the Long Term Care Homes Act and Regulations. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 05, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of March, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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