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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 3, 2015	2015_365194_0001	O-001412	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

MACKENZIE PLACE
52 GEORGE STREET NEWMARKET ON L3Y 4V3

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

CHANTAL LAFRENIERE (194), BARBARA ROBINSON (572), KELLY BURNS (554)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 12,13,14,15,16,19,20,21, 2015

Also inspected during the RQI was Critical Inspections; Log# T-249-14,Log# T-723-14, Log# T-1387-14, Log# T-1602-14, Log# T-1229-14 and Log# T-1318-14.

During the course of the inspection, the inspector(s) spoke with Residents, Families, Executive Director (ED), Director of Care(DOC), Assistant Director of Care (ADOC), Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Worker(PSW), Environmental Services Manager (ESM), Cook, Dietary Aide (DA), Housekeepers,Laundry Aides, Office Manager,Physio-Therapist (PT),RAI co ordinator, Programs Manager,Ward Clerk, Staff Education, and Resident and Family Council representatives.

Also completed in the inspection was tour of the building, observation of dining service, interaction between staff:residents, Medication administration, Infection control practices, review of clinical health record, educational records, maintenance records related to water temperatures, housekeeping, general maintenance process, laundry process, internal incident reports, Critical Incident Reports and licensee's policies as required.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s.90(2)(g)(h)by ensuring that procedures are developed and implemented to address that immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius.

Review of the water temperature logs at the nursing station which are to be completed every shift, was completed for the period of November, December 2014 and January 2015.
November 2, 2014 Days in room # 4 Temperature 49.1
November 4, 2014 Days in room # 10 Temperature 49.8
November 5, 2014 Days in room # 13 Temperature 50

November 6, 2014 Days in room # 16 Temperature 49.9
November 8, 2014 Days in room # 22 Temperature 49.5
November 11, 2014 Days in room # 2 Temperature 49.2
November 16, 2014 Eve in room # 17 Temperature 49.4

December 2, 2014 Days in room # 4 Temperature 50.1
December 5, 2014 Days in room # 13 Temperature 49.5
December 10, 2014 Days in nursing station Temperature 54
December 13, 2014 Days in room # 7 Temperature 50
December 14, 2014 Days in room # 10 Temperature 50.2
December 16, 2014 Days in room # 16 Temperature 49.9

Interim ED has indicated that there is no record of any immediate action taken related to the above temperatures that exceeded 49 degrees Celsius. [s. 90. (2) (g)]

2. The licensee has failed to comply with O. Reg. 79/10 s.90(2)(i)(h)to ensure that procedures are developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius.

On January 14, 2015 @ 1600 inspector tested the hot water temperature in the tub room on Maple Lane. The temperature reading on the tub after running the hot water for several minutes read 33.8 degrees Celsius.

The Bath/Shower water temperature log to be taken daily prior to first tub of the day was reviewed by the inspector. The log reviewed indicated that safe water temperature is 38 degrees to 43 degrees Celsius. The only water temperatures documented in the logs reviewed were for December 22, 29, 2014 January 2,5 and 13, 2015 with 4 readings noted below 38 degrees Celsius .

The ADOC was unable to provide any evidence that immediate action was taken for temperatures that were recorded for water temperatures below 38 degrees in the tub room. [s. 90. (2) (i)]

3. The licensee has failed to comply with O. Reg. 79/10 s. 90(2)(k)(h)to ensure procedures are developed and implemented to ensure that water temperatures were monitored once per shift in random locations where residents have access to hot water.

On January 14, 2015 @12:00 hours inspector # 194 noted the hot water temperature in Room # 1 was very hot to touch. Water temperature was taken and noted to be 61 degrees Celsius, Room # 5 was also tested and noted to be at 61 degrees Celsius.

DOC has confirmed that Registered staff are to take a water temperature every shift as per indicated on the water temperature record. If a temperature exceeds the 49 degree Celsius, a manager is to be notified so that immediate action can be taken.

Review of the water temperature logs at the nursing station to be completed every shift was reviewed by the inspector for the period of November, December 2014 and January 2015.

In November 2014 the water temperature record form should have recorded 94 temperatures. Only 26 temperatures were taken, with eight entries exceeding the 49 degree Celsius.

In December 2014 the water temperature record form should have recorded 94 temperatures. Only 15 temperatures were taken, with six entries exceeding the 49 degree Celsius.

In January 2015 only one entry had been completed, for January 13, 2015 with a temperature reading of 51.6 degrees Celsius in room# 7.

No evidence was provided to the inspector related to the immediate action taken with water temperatures above the 49 degree Celsius. [s. 90. (2) (k)]

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. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (a), by ensuring the home, furnishings and equipment are kept clean and sanitary.

The following observations were made during the dates of January 12, through to January 15, 2015:
- Toilets – brownish or reddish staining and or grout was observed at the base of the toilet and/or along the washroom flooring in rooms #3, 4, 5, 6, 12, 16, 17, 19 and the communal washroom located near the large dining room
- Flooring – scuffed (black marks) are visibly soiled with dust or debris (along wall/baseboard edges) in rooms #7, 12, 14, and 16
- Privacy Curtains – soiled or stained in room #6 (two residents) and room #19
- Windows/Screens – overlooking courtyard in large dining room noted to be covered in thick, dark grey dust or cobwebs
- Bath Chair/Lift – located in the Maple Lane Spa, noted to have whitish film covering seating and back of this device (Note: tub was dry at the time of this observation)

The Environmental Services Manager indicated that the expectation is the home is kept clean at all times. [s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s. 15 (2) (c), by ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following observations were made during the dates of January 12, through to January 14, 2015:

-walls-scuffed (black marks), or scraped in rooms # 3,4,11,12,16,19 and Acorn Lounge; Maple Lane Spa Room corner of wall (adjacent to the end of the tub) has a hole in it, the steel corner bead is exposed and noted to have sharp edges.
- Door Frames – scuffed and/or paint chipped, noted in rooms #3, 4, 6, 7, 10, 15, 16, 19 and within the Maple Lane Spa Room
- Ceiling Tiles – yellowish stains (query water damage) or damaged (chipped) in room #8 and some areas within Maple Lane hallway and spa room
- Flooring Tiles – chipped or cracked in rooms #5, 6, 10, 11, 19, and the Palliative Care Room
- Flooring - duct tape is covering the door threshold (entry) leading into resident room #7; duct tape is lifting (note: presents a potential trip/fall hazard)
- Wall Guard or Baseboard – scuffed (black marks) are loose in rooms #3, 12, 15 and in the Palliative Care Room
- Furnishings – home owned chairs – chair legs have blackish staining and varnish is worn off, leaving porous wood surface exposed in room #6 (Note: porous surface is difficult to clean and poses a potential infection control risk)
-A majority of dining room tables – frame legs/pedestal are scratched and paint has chipped off leaving metal exposed.
- Windows – many resident rooms within the home noted to be missing window opening levers or the levers do not allow windows to be opened. The window in the large dining room, overlooking the courtyard, was observed to have broken window levers, had duct tape hanging off window edges and the window was open; this window was unable to be closed by inspector during the initial home tour. (Note: the temperature outdoors on January 12, 2015, was below 0 degrees Celsius).
- Window Sill – laminate finishing loose in large dining room.
- Palliative Care Room - flooring tile in front of bed cracked / wall guard missing corner at entry to washroom.

The Environmental Services Manager indicated that the home has a computerized system (Maintenance Care) that registered staff and managers could access if they noted areas within the home needing repair, but indicated maintenance issues such as scuffed, scratched or minor damage would not be captured in the electronic system; ESM indicated keeping a small note book with him as to areas he identifies as needing cosmetic repair.

Environmental Services Manager indicated being aware of areas within the home needing repair, replacement and or painting. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: 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 comply with LTCHA, 2007 s. 20 (1) to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy "Resident Non-Abuse-Ontario" (LP-C-20-ON) states that any staff member or person who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the Executive Director of the Home or, if unavailable, to the most senior Supervisor on shift at that time.

The DOC has stated that it is the home's prevailing practice that the Management of the home would be responsible to ensure that the Director was immediately notified related to abuse, calling of police and the completion of the report to the MOHLTC.

Log# T-1387-14

As per Critical Incident submitted on identified date, Dietary Aide #S133 observed

Resident #53 being sexually inappropriate with Resident #8. The Aide reported the incident to RN #S131.

In an interview RN #S131 stated that she was busy and so did not notify the DOC until the following day. The DOC immediately notified the Director and the police.

On an identified date an RPN responded to an altercation where Resident #24 physically assaulted Resident #14 causing injury. RPN immediately notified the DOC and the RN of the incident. The incident was not immediately reported to the Director.

Log# T-723-14

On an identified date an allegation of sexual abuse from Resident #51 was brought forward to the charge nurse, involving Resident #50 and the incident was not immediately reported to the Director

Log# T-249-14

On an identified date an incident of sexual abuse was witnessed by PSW staff involving Resident #50 and Resident #52. The incident was reported to the RN and the incident was not immediately reported to the Director. [s. 20. (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 ensuring 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, to be implemented voluntarily.

WN #4: 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 a person who has reasonable grounds to suspect that abuse of a resident by someone was immediately reported to the Director.

Log# T-723-14

On an identified date Resident #51 brought forward to the charge nurse an allegation of sexual inappropriate touching by a co-resident #50. The incident was not immediately reported to the Director.

Log# T-249-14

On an identified date a PSW witnessed an incident of sexual abuse of Resident #52 by a co-resident #50. The Critical Incident report was submitted to the MOHLTC 3 days later.

On an identified date Registered staff responded to an incident where Resident #24 physically assaulted Resident #14 causing injury and the incident was not immediately reported to the Director.

Interview with DOC confirms that the licensee's policy and prevailing practice in the home is that anyone who becomes aware of abuse is to report it to the administration, who would then contact MOHLTC. The DOC was unable to provide evidence that the Director was immediately notified of the above incidents when interviewed. [s. 24. (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 by ensuring that a person who has reasonable grounds to suspect that abuse of a resident has occurred is immediately reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 53 (4)(d) to ensure that actions were taken to respond to the Responsive behaviour needs of the resident including assessments, reassessments and interventions.

A review of the health care record of Resident #53 indicates that the resident has multiple co-morbidities. The resident was referred to the Behaviour Supports Ontario program (BSO-Loft) for sexually inappropriate behaviours and comments involving staff members. He was involved in the following two sexual inappropriate behaviours with two separate residents between a three month period.

Log # T-1387-14
On an identified date, as per the Critical Incident Report, Dietary Aide #S133 observed Resident #53 being sexually inappropriate with Resident #49. At the time of the incident, staff were monitoring Resident #53 closely with the Dementia Observation Scale (DOS) every 15 minutes.

Log # T-1602-14
Two months later, as per the Critical Incident Report, Resident #8 stated that Resident #53 had been sexually inappropriate towards the resident. Staff continued to closely monitor the resident's interactions with other residents and the DOS was restarted.

After the initial incident, a repeat referral to Loft was made and the creation of a Behaviour Support Plan dated one month later was initiated. The plan primarily contained interventions to address behaviours with inappropriate sexual behaviour with staff. The

only intervention recommended to prevent further incidents with residents was to inform the resident that non-consensual sexual behaviours were unlawful and could result in police being called but Resident #51 had been assessed with poor memory retention.

The Care Plans for Resident #53 over a seven month period are unchanged and describe two interventions;
-to notify the physician/NP of any behavioural status change
-to continue monitoring the resident closely with interventions as per the Behaviour Support Plan from Loft (informing the resident that the police may be called).

Interviews with the ADOC, RPN #S108, RN #S109, RN #S131and RPN #S132 indicated close monitoring of Resident #53 was the only intervention in place to prevent further sexual behaviours with other residents after the initial incident and no further interventions have been initiated since the second incident two months later.

In an interview with the DOC confirmed that actions were not taken to respond to the needs of the Resident #53 including assessments, reassessments and interventions. [s. 53. (4) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that actions were taken to respond to the Responsive behaviour needs of the resident including assessments, reassessments and interventions., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between Resident #24 and other residents based on information provided to the licensee or staff through observations, that could potentially trigger such altercations.

During the interviewing process of stage #1 of the RQI Resident #24 identified a physical altercation with the Resident #14.

On an identified date the progress notes indicate an altercation where Resident #24 threatens Resident #14.
It is documented that the staff attempted to calm resident #24 when the Resident struck the PSW and punched the RPN in the abdomen. RN called a code white. Resident #14 was moved to another room for the night.

Two days later the progress notes indicate that Resident #24 threatened a table mate with physical injury.

Fourteen days after the previous incident the progress notes indicate that Resident #24 was upset about Resident #14.

Approximately one month after the last incident, the progress notes for Resident #24 indicate that the Resident had been physically abusive towards Resident #14. Resident #24 was moved to another room.

A physician's order for medication when required for aggression and agitation was received after the first incident. DOS monitoring was initiated and response behaviour charting every 15 min on Point of Care (POC) was initiated.

Review of the plan of care for Resident #24 was completed related to Responsive Behaviour. There were no changes to the plan of care after the three incidents of related to aggression towards co-residents. Changes to the plan of care to include aggression towards other residents were included after the last incident, but fails to identify triggers or provide interventions to minimize the risk of further altercations between residents. [s. 54. (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 by ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, s. 60(2) to respond to concerns or recommendations about the operation of the home within 10 days of receiving the advice to the Family Council, in writing.

During an interview on January 13, 2015 the President of the Family Council noted that the home responds to concerns raised by the Family Council, but she was not sure if all of the concerns received a written response within 10 days.

On January, 13, 2015 the minutes of the Family Council meetings from April 3 to October 14, 2014, were reviewed. On July 3, 2014 members expressed concerns about laundry labels falling off clothing and laundry being placed in the wrong closets, as well as not enough chairs in residents' rooms. A written response was provided to Council on October 3, 2014.

On October 14, 2014 members again raised concerns about laundry being placed in wrong closets, not enough chairs in residents' rooms and residents being dressed in clothing that did not belong to them. A written response was provided to council on November 4, 2014.

In an interview on January 20, 2015, the ED confirmed that the licensee did not respond to concerns or recommendations about the operation of the home to the Family Council, within 10 days, in writing. [s. 60. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, s. 85(3) to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview on January 13, 2015 the President of the Family Council noted that the licensee provides the Council with the results of the satisfaction survey, but the licensee does not seek the advice of the Council in developing and carrying out the survey. The Program Manager stated that the Resident Council was engaged in the creation of the satisfaction survey, but not the Family Council.

On January 20, 2015, the ED confirmed that the licensee did not seek the advice of the Family Council in the developing of the satisfaction survey. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 89 (1)(a)(iv) to ensure that, as part of the organized program of laundry services that procedures are developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

In an interview on January 13, 2015, the Substitute Decision Maker (SDM) of Resident #3 noted that the Resident had lost a number of clothes.

Resident #12 stated that items were missing and reported it to staff.

In an interview on January 15, 2015, PSW #S122, RPN #S125 and RPN#S108 stated that if residents are missing clothing, staff will search for the items in rooms and the laundry area. Staff would communicate the loss in various ways that include a verbal discussion or an entry in the communication book.

In an interview on January 15, 2015 with the DOC, she confirmed that there is not an identified process to locate missing clothing or personal items. [s. 89. (1) (a) (iv)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Log# T-1602-14

The licensee failed to comply with O.Reg 79/10 s.98 to ensure that the appropriate police force was immediately notified of any alleged, suspected or witnessed incident of abuse of a resident that the licensee suspects may constitute a criminal offence.

As per Critical Incident on a identified date, Resident #8 stated that Resident #53 had been sexually inappropriate.

In an interview on January 19, 2015 the DOC confirmed that she was notified immediately but did not notify the police because the resident did not want a police report submitted. [s. 98.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the incident, type of incident, area of location of the incident, date and time of the incident, and events leading up to the incident.

Interview with DOC was completed and she confirmed that no written report was submitted to MOHLTC related to the incident of an identified date involving Resident #24 and resident #14 for physical abuse that resulted in injury. [s. 104. (1) 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 111 (1), by ensuring that the PASD used to assist the resident with routine activity of living is removed as soon as it is no longer required to provide such assistance.

The following observation was made during the dates of January 14 (afternoon) and again at approximately 10:00hrs on January 15, 2015:

-½ bed rails (2) were observed engaged (elevated), and positioned mid bed; Resident #12 was not in bed during these observation

RN #S107, in a charge nurse role, indicated that the ½ bed rails (2) are used during the night to assist Resident #12 in turning and repositioning; staff indicated bed rails were being used as a PASD. RN #S107 indicated the bed rails (2) are utilized during the day, when resident is not in bed to keep Resident #12 from getting into bed unassisted by staff. RN #S107 indicated Resident #12 would attempt to self transfer into bed if bed rails were not elevated, causing a potential fall.

The written care plan does not include bed rails being elevated during the day as a Falls Prevention Strategy used for transferring nor is there evidence that Resident #12 or Resident's family requested bed rails being retained when resident is not in bed.

The Director of Care indicated that bed rail usage is not intended to keep residents out of their bed; and was not the intended or approved use for Resident #12. [s. 111. (1)]

Issued on this 3rd day of February, 2015

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), BARBARA ROBINSON (572), KELLY BURNS (554)
Inspection No. / No de l'inspection :	2015_365194_0001
Log No. / Registre no:	O-001412
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 3, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	MACKENZIE PLACE 52 GEORGE STREET, NEWMARKET, ON, L3Y-4V3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laurie Hamelin

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 :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall ensure that procedures are developed and implemented to address;
-The temperature of the water serving all bathtubs, showers and hand basins used by residents does not exceed 49 degree Celsius
-Immediate action is taken to reduce the water temperature in the event that it exceeds 49 degree Celsius
-the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius
-if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.
-A monitoring system is implemented to ensure compliance of the above

Grounds / Motifs :

1. On January 14, 2015 @12:00 hours inspector # 194 noted the hot water temperature in Room # 1 was very hot to touch. Water temperature was taken and noted to be 61 degree Celsius, Room # 5 was also tested and noted to be at 61 degree Celsius.

DOC has confirmed that Registered staff are to take a water temperature every shift as per indicated on the water temperature record. If a temperature exceeds the 49 degree Celsius, a manager is to be notified so that immediate action can be taken.

Review of the water temperature logs at the nursing station to be completed every shift was reviewed by the inspector for the period of November, December 2014 and January 2015.

In November 2014 the water temperature record form should have recorded 94 temperatures. Only 26 temperatures were taken, with eight entries exceeding the 49 degree Celsius.

In December 2014 the water temperature record form should have recorded 94 temperatures. Only 15 temperatures were taken, with six entries exceeding the 49 degree Celsius.

In January 2015 only one entry had been completed on January 13, 2015 with a temperature reading of 51.6 degree Celsius in room #7.

No evidence was provided to the inspector related to the immediate action taken with water temperatures above the 49 degree Celsius.

Review of the water temperature logs at the nursing station which are to be completed every shift, was reviewed for the period of November, December 2014 and January 2015.
November 2, 2014 Days in room # 4 Temperature 49.1
November 4, 2014 Days in room # 10 Temperature 49.8
November 5, 2014 Days in room # 13 Temperature 50
November 6, 2014 Days in room # 16 Temperature 49.9
November 8, 2014 Days in room # 22 Temperature 49.5
November 11, 2014 Days in room # 2 Temperature 49.2
November 16, 2014 Eve in room # 17 Temperature 49.4

December 2, 2014 Days in room # 4 Temperature 50.1
December 5, 2014 Days in room # 13 Temperature 49.5
December 10, 2014 Days in nursing station Temperature 54
December 13, 2014 Days in room # 7 Temperature 50
December 14, 2014 Days in room # 10 Temperature 50.2
December 16, 2014 Days in room # 16 Temperature 49.9

Interim ED has indicated that there is no record of any immediate action taken related to the above temperatures that exceeded 49 degree Celsius.

On January 14, 2015 @ 1600 hours inspector tested the hot water temperature in the tub room on Maple Lane. The temperature reading on the tub after running the hot water for several minutes read 33.8 degree Celsius.

The Bath/Shower water temperature log to be taken daily prior to first tub of the day was reviewed by the inspector. The log reviewed indicated that safe water temperature is 38 degree to 43 degree Celsius. The only water temperatures documented in the logs reviewed were for December 22, 29, 2014 January 2,5 and 13, 2015 with 4 readings noted below 38 degree Celsius .

The ADOC was unable to provide any evidence that immediate action was taken for temperatures that were recorded for water temperatures below 38 degree Celsius in the tub room. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
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
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 3rd day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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