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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 11, 2014	2014_240506_0008	H-000297-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

NORTHRIDGE
496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2

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

LESLEY EDWARDS (506), ASHA SEHGAL (159), CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)

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): March 18, 19, 20, 21, 24, 25,26 and 27, 2014.

The following Critical Incident System inspections were completed concurrently with the RQI-H-000822-13,H-000831-13,H-000857-13,H-000231-14 and H-000328-14

During the course of the inspection, the inspector(s) spoke with Executive Director, Acting Executive Director,Regional Manager, Director of Care(DOC), Staff Educator, Staffing Co-ordinator,Resident Assessment Instrument Co-ordinator(RAI),Recreation Manager, Office Manager, Staff Educator,Environmental Service Manager,laundry and housekeeping staff,Food Service Manager(FSM),Registered Dietician,Registered Nursing staff (RN/RPN),Personal Support Workers(PSW),dietary staff,family members and residents.

During the course of the inspection, the inspector(s) toured the home, reviewed care and services provided on all home resident home areas, reviewed records including but not limited to health care records, meeting minutes, investigation notes and polices and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the home's policy "Weight Management" LTC-G-60 revised date August 2012 was complied with related to Residents # 819, #199, #817 and # 877. The policy directed the staff residents will be weighed and weight documented by the 7th day of each month. If a weight loss or gain is 2.0kg or greater from the preceding month, a re-weigh will be completed immediately. The following identified residents did not have re-weighs completed immediately and entered into POC. Resident #819 weights were recorded as: June 2013 - weight 47.8 kg, July 2013- 50.9 kg, August 2013 - 44.0kg, September 2013 -49.0kg. Resident #199 weights were recorded as: June 2013 -37.2kg, July 2013-34.5kg, December 2013-35.2 kg and January 2014 29.5kg. Resident #817 weights were recorded as: July 2013-59.1 kg, August 2013-49.3 kg
Resident # 877 weights were recorded as: October 2013-60.4 kg, November 2013-57.3 kg, December 2013-55.3kg, January 2014- 53.3 kg and February -47.1 kg, [s. 8. (1) (b)]

2. The licensee did not ensure that the plan, policy, protocol, procedure, strategy or system for staff immunization was complied with. The home's Infection Control Policy # HR D 70: Immunization/Testing Required Upon Hire, Effective as of January 1998 and revised on June 2013 stated that "Newly hired employees are required to provide valid documentation, (Employee immunization and TB testing record) [HS17-T-20], confirming immunization or immunity to the following as a condition of employment: measles, mumps, rubella (MMR), varicella, hepatitis B, tetanus, diphtheria, acellular pertussis (Tdap) and tuberculosis mantoux screening/testing". On March 21, 2014, six staff records were reviewed for evidence of compliance with the staff immunization program. Four did not contain documentation confirming staff immunity or immunization for conditions according to the policy including MMR, varicella, hepatits B, and Tdap. The Office Manager confirmed that immunization records were not present in these staff files and could not confirm staff immunization or immunity status. [s. 8. (1) (b)]

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to resident #197 as specified in the plan. Resident #197 did not receive care as specified in the plan of care related to fluid restriction. The attending physician of the resident had ordered a fluid restriction of 1500 ml/day. The plan of care and the diet reference list in the dining room had directed the staff to provide 375 millilitres(mls) fluid at each meal and 125 mls fluid at each nourishment. On identified dates in March 2014 resident #197 was observed in the dining room during the meal service. On an identitifed date in March 2014 resident received at lunch 125 ml cranberry juice, 200 ml milk, 200 ml water and 180 ml coffee, which was contrary to the amount of fluid stated in the plan of care. On an identified date in March, 2014 resident was served 200ml milk, 200 ml water, 125 ml juice and a small mug of coffee. The staff interview confirmed resident's fluid intake exceeded the fluid restriction. The PSW did not refer to the diet list when serving the beverages to resident [s. 6. (7)]

2. The Licensee did not ensure that the resident was reassessed and the plan of care reviewed and revised when the care needs change. Resident #199 plan of care indicated resident was a high risk for falls. Resident #199 experienced a fall on an identified date on December 2013 with no revision of the plan of care as indicated in the progress notes. On an identified date on December , 2013 the resident sustained another fall requiring hospitalization. Interventions were not reviewed or revised until the resident returned from the hospital on an identified date on January 2014. This information was confirmed by the health record and the DOC could not confirm that the plan of care had been reviewed or revised after the fall. [s. 6. (10) (b)]

3. Resident #877 plan of care indicated that resident's pressure ulcer was healed.

The plan of care was not reviewed or revised when the resident's care needs changed to indicate that the pressure ulcer had healed. Instead the plan of care indicated that staff were to change the dressing weekly and whenever necessary. The RN confirmed that the pressure ulcer had resolved and the plan of care should have been updated to reflect residents current interventions. [s. 6. (10) (b)]

4. Resident #819 plan of care indicated that resident's pressure ulcer was healed. The plan of care was not reviewed or revised when the resident's care needs changed to indicate that the pressure ulcer had healed and no longer required the pressure ulcer interventions. The plan of care indicated that staff were to assess resident's pressure ulcer with every dressing change for signs of infection, induration and odour and staff were to administer pain medications prior to a dressing change. The RN confirmed that the pressure ulcer had resolved and the plan of care should have been updated to reflect resident's current interventions. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out the planned care for the resident and that residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee did not ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents. On March 18, 2014 at approximately 1030 hours on home areas Post House and Mill House, doors leading to the second floor outdoor balcony could be opened and were not equipped with locks. Staff indicated that the doors should be padlocked during the winter months and could not lock the doors. Between March 19 and March 25, 2014 the doors were not equipped with a lock. The Executive Director and the Environmental Service Manager confirmed that the doors were not equipped with locks to restrict unsupervised access by residents to the second floor balcony. [s. 9. (1) 1.1.]

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 and ensuring that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, bed systems were assessed in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. On June 1, 2012 the home commissioned an external agency to conduct an assessment of bed system entrapment risk. On that day 106 beds were assessed and 33 beds were not assessed. Of the 106 beds assessed, 81 (76.4%) beds failed for entrapment risk and mattresses were replaced. On March 20 and March 25, 2014 the Environmental Service Manager and Executive Director confirmed that a)these new bed systems were not reassessed for entrapment risk; b) another complete assessment had not been done since 2012; c)the bed systems that were not assessed in 2012 have not been assessed; and d) bed systems for new residents were not assessed on admission to minimize entrapment risk. The Executive Director confirmed that there was not a procedure in place to ensure regular assessment of bed systems to minimize risk to residents. [s. 15. (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 the resident is assessed and his or her bed system is evaluated in accordance with evidenced based-practices and, if there are none, in accordance with prevailing practices, to minimize the risk to residents, to be implemented voluntarily.

WN #5: 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 did not ensure that residents were protected from abuse by anyone and were not neglected by the licensee or staff.

A)On an identified date in November, 2013 resident #400 reported to the Registered Staff on duty that on an identified date in November, 2013 a staff member had turned off the lights in resident #400's room despite being asked by the resident to leave the light on.
B)A review of the home's investigation notes and confirmation from the DOC and the CIS report submitted to the Director confirms that this incident did occur.
C)The PSW was disciplined. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident shall be protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff,, to be implemented voluntarily.

WN #6: 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. A) The RD did not assess resident # 877's hydration status at the significant change in status assessment. The Nutritional Status and the Dehydration /Fluid Maintenance triggered Resident Assessment Protocols (RAP) had identified resident was receiving a specialized treatment, recent hospitalization, weight loss, decreased in intake. The RAP summary documented by the Food Service Manager stated " weight loss in one month, no significant change in intake, will continue with current

plan" There was no assessment of the resident's poor hydration or interventions to address the concerns related to poor intake and weight loss. The resident had a significant loss over three months, which triggered a weight loss warning. A dietary referral was made for weight loss, re-admission after recent hospitalization, and diet texture assessment. The Registered Dietitian's documented Nutrition Care notes stated " decreased intake, texture change likely contribute to weight loss, Intake adequate to meet -75 percent caloric needs, 100 percent protein and hydration needs. Resident remains at High nutritional risk." The RD reassessed the Goal Weight Range (GWR), and lowered the value. However, interventions were not revised nor action taken to address the ongoing unplanned weight loss and poor hydration. The resident had a further significant weight loss over three months. A referral was made to the Registered Dietitian for reassessment of resident's diet and weight loss. The nutrition notes documented in the progress notes by the RD stated "Resident's over all intakes is fair at meals. Fluid intake was improved initially showing signs and symptoms of dehydration and intervention were in place by nursing to encourage fluid intake. Recommend continue with current diet order as tolerated by resident. The resident was noted to have a significant weight loss warning triggered and poor hydration. The RD did not assess hydration status at the time in relation to the weight loss. The plan of care was not revised to address the issues related to ongoing unplanned significant weight loss and poor hydration.

B) Resident #199's plan of care identified that the resident was at increased risk for dehydration related to chronic infection and cognitive state and decreased independent access to fluids. The Minimum Data Set (MDS) Quarterly assessment was completed. The RAP summary for Nutritional Status was documented by the RD and had identified food intake average, current weight below the Goal Weight Range (GWR) Body Mass Index (BMI), gradual undesirable weight loss over the past six months. Resident remains at moderate nutritional risk. The RD did not assess resident's hydration status. The interventions were not evaluated and different approaches were not taken in the revision of the plan to address identified concerns related to low BMI, weight below the GWR. The resident was assessed at moderate risk level in spite of noted nutritional concerns.

C) The progress notes for resident #198 had identified a dietary referral was made by the nurse practitioner to RD to reassess resident for ongoing unplanned weight loss, and food intake decreased by less than 25 percent at most meals. The nutrition care notes documented by the RD. Overall intake not likely adequate to meet assessed needs". Action was not taken by the RD to address the nutritional concern related to poor oral intake and weight loss. The progress notes stated that the resident was

consuming less than 50 percent of meals and also often refusing supplement. Resident had weight loss and was referred to the RD. The nutrition notes completed by the RD stated "food intake less than 25 percent at most meals". Resident was assessed for increased risk of under nutrition and dehydration and supplement order was reviewed and revised. The RD did not assess resident's hydration status and concerns related to poor oral intake when the resident's intake was less than 25 percent at most meals. The progress notes identified dietary referrals were made by nursing. The referrals were made to the RD to reassess resident for weight loss over three months and food intake at meals. The review by the RD related to the nursing referrals did not include an assessment of the resident in relation to weight loss and poor hydration. The monthly weight records indicated resident had weight loss over one month. The plan of care had stated resident at risk for malnutrition secondary to poor intake; severe underweight status, and poor hydration. The Registered Dietitian did not assess the resident for ongoing unplanned weight loss, poor hydration. The plan of care was not reviewed and revised and different strategies/ measures were not taken to address poor food intake, hydration and a significant weight loss. [s. 26. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff, assesses the nutritional status, including height, weight and any risks relating to nutrition care and hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee did not consult regularly with the Family Council at least every three months. A review of the Family Council meeting minutes and the Family Council member interview confirmed the home had not consulted with Family Council since August 2013. The home was unable to provide supportive documentation that the Family Council was regularly consulted. [s. 67.]

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 and to ensure that the licensee consult regularly with the family council, if any, and in any case shall consult with them at least every three months, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee did not ensure that residents with weight changes were assessed using interdisciplinary approach, and that action was taken and out comes were evaluated in relation to significant weight loss for resident #817. A significant weight loss warning was triggered for significant weight loss over one month. The progress notes documented by RD had stated "significant and undesirable weight loss due to decreased intake in previous months. High cal interventions not considered as appetite improving. Continue diet and supplement order". The RD completed the follow-up for weight loss and decreased intake, however, outcomes were not evaluated, and nutritional strategies were not revised, despite a significant unplanned weight loss, poor oral intake and the GWR. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee did not ensure that all foods are prepared and served using methods that preserved taste, nutritive value, appearance and food quality [s. 72(3) (a)]
On an identified date in March, 2014 the dietary staff was observed preparing food and did not follow standardized recipes. Menu items i.e. chicken pie, minced and pureed menu items were observed to be prepared not using standardized food production processes i.e weighing /measuring of ingredients for quality consistency. The recipe for chicken pie indicated preparation of pie crust home-made on site, however, out sourced frozen product was used. The minced chicken pie recipe did not provide clear direction for staff. The recipe stated to use mince prepared product to desired consistency, however, regular chicken pie was served. The recipe for puree chicken pie was different than the method used by staff preparing pureed chicken. Food Service Manager confirmed the new Winter/Spring menu cycle was implemented three weeks ago and the recipes were not modified and adjusted to home specific. [s. 72. (3) (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 all food and fluids in the food production system are prepared, stored, and served using methods to, preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that residents who required assistance with eating or drinking were served a meal until someone was available to provide assistance required by residents.
During the observation on an identified date in March, 2014 of the breakfast meal service in a home area residents who required total assistance with their meals, their beverages were served including milk, and left in front of the residents at 0905 hours. However, residents did not receive assistance until 1005 hours. The residents waited greater than one hour as the staff was not available to assist residents with eating. Two residents were observed to be served hot cereal without assistance being provided. Food items were left in front of the residents for period of greater than 10 minutes. The PSW left the residents unattended and went to serve tea/coffee to other residents. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any resident requiring assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #11: 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. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee did not make available to the Family Council results of the satisfaction survey to seek advice of the Council on the survey.
There was no documentation that the home provided the 2012/2013 satisfaction survey results or sought the advice of the Family Council. Interview with the member of the Family Council and the Executive Director confirmed the results of the survey were not made available. [s. 85. (4) (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 at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program.

A) On an identified date in March, 2014 inspector observed unlabelled and used toothbrushes in shared bathrooms.
B) On an identified date in March, 2014 the spa room on a home area had two unlabelled roll on deodorants that were used, two used combs,a used bottle of cold cream and 6 nail brushes that were noted to have debris and hair in them. [s. 229. (4)]

2. During identified dates in March 2014, signage on resident #877's room indicated that they were to be cared for using contact precautions. On an identified date in March soiled laundry was observed lying on the floor near the door. On an identified date in March dirty linen was observed again on resident #877's room floor. On an identifed date in March PSW, housekeeping staff and the DOC confirmed that soiled laundry should not be placed on the floor. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the infection prevention and control program required complies with this section to ensure that staff participate in the implementation of the program. The licensee shall ensure they is a staff immunization program in accordance with evidenced based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident had the right to communicate in confidence, receive visitors and consult in private with any person without interference.
On a identified date in March, 2014 the inspector's were conducting interviews with three residents at different times throughout the day and on different home areas. During each of the three interviews with resident's #891, #900 and #867, the door to the resident's rooms were closed when staff member's entered the rooms without knocking or announcing their presence prior to entering. [s. 3. (1) 14.]

WN #14: 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 did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A) On an identified date in March, 2014 furnishings in lounge areas on Post House noted to be in disrepair including the TV unit which had chunks and gouges out of the wood and an arm chair which had rips and chunks out of the upholstery. Environmental Service Manager confirmed that furnishings were damaged and could not confirm that there was a process to repair or replace damaged furnishings.
B) On an identified date in March hand rails in resident areas noted to have sharp edges and broken areas, particularly near corners. Staff confirmed that hand rails were rough around some corners. Environmental Service Manager confirmed that no regular inspection of grab rails were in place. [s. 15. (2) (c)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee did not ensure the staffing plan provided for a staffing that was consistent with residents' assessed care needs and safety needs and that met the requirements set out in the Act and this Regulation. On an identified date in March, 2014, the breakfast meal service on a home area was not organized to meet the needs of residents as evidenced by residents having to wait extended periods of time to receive assistance into the dining room and during the breakfast meal. The dining was observed beginning at 0830 hours with approximately ten residents present. At 0905 hours there were sixteen residents in the dining room and there was only one PSW in the dining room setting up beverages on the dining tables. The dietary aide interviewed confirmed the scheduled breakfast start time is 0830 hours; however, they were unable to serve breakfast as most of the residents in the dining room required total physical assistance with eating and the PSWs were not available to assist residents. The residents who were in the dining room prior to 0830 hours, the scheduled breakfast start time, were not served breakfast until 0910 hours, when Registered Practical Nurse (RPN) was available to assist residents with eating. At 0930 hours two residents at the table # 4 were observed to be served hot cereal without assistance being provided. The PSW left the bowls of cereal in front of the residents and went to serve tea/coffee to other residents. The plans of care had indicated that the residents required total assistance with eating. At table # 3 four residents who required total assistance with eating and drinking their beverages were left in front of them for period of greater than 45 minutes. These residents received the required assistance with their meals after 1005 hours. At 1015 hours the inspector observed a PSW serving the breakfast meal tray in a resident's room. The Dietary Aide confirmed that residents receiving meal trays in their room were served at the end of the dining room service when nursing staff was available to serve and assist residents with their meals. The RPN interviewed reported the usual staffing deployment for PSWs on this home area for day shift was two PSWs 0700-1500 hours and one PSW 0700-1330 hours. Nursing staff and the Director of Care interviewed reported that the observed shift was "typical" for a day shift in the home. As most residents on this home area require extensive assistance with morning care routine and as result residents at times arrive late for breakfast. [s. 31. (3) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that residents were transferred using safe transferring and positioning techniques.

On an identified date in December, 2013, resident #896 was assisted using a mechanical lift with only one staff person while transferring resident. Resident #896 was noted in their plan of care to require assistance of two staff with using a mechanical lift. The home conducted an investigation into the incident and determined that the staff member did not have two staff members present for the transfer and did not follow the home's policy regarding mechanical lifts. The employee received disciplinary action as a result of the incident and further education on safe transferring and positioning techniques. [s. 36.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers,skin tears or wounds were assessed at least weekly by a member of the of the registered nursing staff.

A)Resident #911 was identified to have a significant pressure ulcer on their buttocks. The weekly wound assessment was conducted only four times between the months of December 2013 and March 15, 2014.
B)Resident #846 was identified to have a significant pressure ulcer on their right and left buttock. The weekly wound assessment was conducted three times between the months of December 2013 and March 15, 2014.
C)This information was confirmed by the RAI co-ordinator and the health record. [s. 50. (2) (b) (iv)]

Issued on this 11th day of April, 2014

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

Lesley Edward

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) :	LESLEY EDWARDS (506), ASHA SEHGAL (159), CATHIE ROBITAILLE (536), THERESA MCMILLAN (526)
Inspection No. / No de l'inspection :	2014_240506_0008
Log No. / Registre no:	H-000297-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 11, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	NORTHRIDGE 496 POSTRIDGE DRIVE, OAKVILLE, ON, L6H-7A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leslie Harris

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

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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan that outlines how the home shall ensure the policy for Weight Management is complied with. The plan shall be submitted electronically by May 1, 2014 to Asha Sehgal at asha.sehgal@ontario.ca

Grounds / Motifs :

1. This section was previously issued as a VPC in October 2013.
The licensee did not ensure that the home's policy "Weight Management" LTC-G-60 Revised date August 2012 was complied with related to Residents # 819, #199, #817 and # 877. The policy directed the staff residents will be weighed and weight documented by the 7th day of each month. If a weight loss or gain is 2.0kg or greater from the preceding month, a re-weigh will be completed immediately. The following identified residents did not have re-weighs completed immediately and entered into POC. Resident # 819 weights were recorded as: June 2013 - weight 47.8 kg, July 2013- 50.9 kg, August 2013 - 44.0kg, September 2013 -49.0kg.
Resident # 199 weights were recorded as: June 2013 -37.2kg, July 2013-34.5kg December 2013- 35.2 kg and January 2014 29.5kg. Resident #817 weights were recorded as: July 2013-59.1 kg, August 2013-49.3 kg Resident # 877 weights were recorded as: October 2013-60.4 kg, November 2013- 57.3 kg, December 2013-55.3kg, January 2014- 53.3 kg and February -47.1 kg, (159), r. 8. (1)(b) (159)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2014

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 11th day of April, 2014

Signature of Inspector / Signature de l'inspecteur : Lesley Edwards

Name of Inspector / Nom de l'inspecteur : Lesley Edwards

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