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
Dec 3, 2014	2014_333577_0008	S-000206-14	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

ROSEVIEW MANOR
99 SHUNIAH STREET THUNDER BAY ON P7A 2Z2

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

DEBBIE WARPULA (577), KARI WEAVER (534), LAUREN TENHUNEN (196)

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): June 9-13 and 16-20, 2014.

The following logs were reviewed as part of this Resident Quality Inspection: S-000103-14, S-000320-13, S-000139-13, S-000242-13, S-000242-13, S-000241-13, S-000329-13 & S-000302-13

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Recreation, Environmental Services Manager, Nutrition Manager, Pharmacist, Resident Services Coordinator, Registered Dietitian (RD), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides (DA), Housekeeping Staff, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

- **16 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 229. (4)	CO #001	2013_211106_0006	196
O.Reg 79/10 s. 55.	CO #001	2013_104196_0006	577
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2013_104196_0005	196
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #002	2013_211106_0006	534

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. 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. Inspector #534 made note of a foul odor coming from resident #400. The following day, inspector observed the same odor as the day before but noted the odor to be more severe. Staff member #S-101 stated that the odor was coming from a dressed wound on resident #400 and was reported to #S-102. The inspector noted that the resident had the wound covered with a transparent absorbent dressing and a large amount of cloudy, brown drainage had pooled under the transparent dressing. The wound odor could be smelled when the inspector was approximately a meter away from the resident. The inspector asked #S-102 if the dressing had been changed when the personal support worker notified them of the wound odor.#S-102 stated the dressing had not been changed because the resident could become combative, would have needed assistance, and they ran out of time. The dressing was not changed on following evening or night shift. Staff #S-102 stated that the wound looked infected and needed to have a culture swab obtained.

The inspector asked the #S-102 when the last time the dressing had been changed and what wound documentation had been completed. Together, the progress notes for the resident were reviewed. The wound was documented as a long skin tear that occurred as a result of a fall. A wound care referral had been sent after the injury had occurred. Documentation about the wound was found on: June 9, 2014 at 1343 h and 1856 h, June 10, 2014, and June 11, 2014 at 0425 h and 1106 h, documenting the wound dressing

was dry and intact. As part of the wound care consult, the dietitian assessed the nutritional needs of the resident. The only documented dressing change occurred on June 17, 2014 at 0503 h. #S-102 stated they had changed the dressing on June 15, 2014 and had noted an odor to the wound but failed to document the finding or the dressing change. They stated that skin tears are only documented weekly in the progress notes and that orders are entered for skin tears to alert staff to assess and monitor but that this was not done. #S-102 stated that their program "hasn't been up to par lately". After interviewing #S-102, the inspector sought out and brought the Director of Care to see the resident's wound.

The licensee has failed to ensure that 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. [s. 50. (2) (b) (ii)]

2. Inspector #577 reviewed the Treatment Observation Record for residents' #335 wound. Documentation shows a 12 day gap, where there isn't documentation showing dressing changes. Upon record review, the initial wound assessment was documented April 14, 2014. Most recent orders written by Wound Care Nurse were on April 10, 2014. Inspector spoke with #S-103 about missing documentation. Reports they don't know if dressing changes were done that week.

The licensee failed to ensure that (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2). [s. 50. (2) (b) (iv)]

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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. During the home's entry tour, inspector #534 found in resident #403's room, various improperly stored prescription medications. One 30gram jar of ointment in the resident's private bathroom and on the surface top of the resident's dresser an expired (2012) bottle of eye drops and 1 small, white, unlabelled pill in a medicine cup. The items were confirmed with staff #S-104, who stated the resident did not have orders for medications at the bedside. Additionally, they were unsure where the unattended, small white pill contained in the medicine cup, had come from or what it was for.

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

2. A container of prescription cream was observed on the bedside table of resident #300. [s. 129. (1) (a) (ii)]

3. In another resident room, there was a basket at the beside with two containers of prescription cream inside. There was a tube of cream and a container of cream labelled with resident #245's name on it.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. [s. 129. (1) (a) (ii)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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:
1. Every resident has the right to be treated with courtesy and respect and in a way

that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements

provided for under this Act. 2007, c. 8, s. 3 (1).
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).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy

affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector #577 overheard #S-104 raising her voice and scolding resident #500 while she was in the common room at the end of hall, 'What are you doing, get out of there, you're acting like a child!'. Inspector #577 met with Director of Care and informed her of witnessed verbal abuse on unit towards resident #500. #S-104 was pulled off the unit and suspended by Director of Care. Inspector received homes abuse policy and employee file for #S-104. Policy states that Revera is committed to providing a safe and supportive environment in which all residents are treated with dignity and respect. Defines verbal abuse as inappropriate tone of voice, swearing, yelling, rude and emotional abuse as intimidation, infantilization, sarcasm, ridiculing, scolding and social isolation. Policy also includes mandatory reporting, to make an immediate report the suspicion and information to the Director of the Ministry of Health and Long-Term Care.

The licensee failed to ensure that the following rights of residents are fully respected and

promoted: 2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1). [s. 3. (1)]

2. A Critical Incident System report was submitted to the MOHLTC previously, outlining an incident in which "staff took a picture of resident #245 while being transferred onto the toilet wearing a brief on their head". According to the report, the resident was upset and embarrassed about the incident and is fully dependent upon the staff of the home for care. This incident did not respect resident #245's dignity.

The licensee has failed to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. [s. 3. (1) 1.]

3. Inspector #534 conducted a family interview related to care provided to resident #204 in the home. The family member of the resident raised concerns about the resident not receiving the required assistance during mealtimes. The resident's family member stated they visit the home many times during the serving of meals to ensure that the resident is assisted with meals. The inspector reviewed the resident's care plan and kardex. The resident's kardex indicated that they required "limited assistance" of "one person physical assist" for eating. The care plan outlined that the resident required the support of one staff to assist frequently for eating due to physical limitations from Parkinson's disease and mouth pain.

During the lunch meal, the resident was noted at 1200 h to be sitting at their assigned table waiting for their lunch meal. The only staff interactions that that resident #204 received during the meal were at 1233 h (medications and mug assistance by #S-105, 1235 (#S-106 offering lunch entrée choice), 1236 h (lunch plate served by #S-106), 1255 h (#S-105 conversing with resident), 1259 h (offer of dessert choice by #S-107), 1300 h (dessert served to resident), and 1335 h when the resident was taken back to their room. The inspector noted the resident to be having a hard time using a fork for their pasta and Caesar salad. Multiple times the food items fell off the fork onto the plate or the resident was having difficulty with using the fork. After approximately 20 minutes of attempting to use the fork, the resident switched to eat their salad and pasta with a spoon. No encouragement or assistance with the meal was noted by any of the staff members present in the dining room.

The licensee has failed to ensure that the following rights of residents are fully respected

and promoted: every resident has the right to be properly fed in a manner consistent with his or her needs. [s. 3. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2. Every resident has the right to be protected from abuse. 3.Every resident has the right to be properly fed in a manner consistent with his or her needs. Specifically in regards to residents #500, 245 and 204, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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. Resident #180 was noted to have bilateral bed rails elevated in the middle of their bed.

The Point of Care kardex as found online and was reviewed by inspector #196 and did not include reference to the use of bed rails while in bed. Care plan as found online in Point Click Care under the focus of "risk for falls" includes the intervention of "put 2 bed rails up at all times when in bed for safety. Check hourly". The hard copy of resident #180's kardex as found in the binder at the nursing desk was reviewed and did not include reference to the use of bed rails while in bed. Interviews were conducted with #S-108 and #S-109. It was reported that two bed rails are used, mid bed, when resident #180 is in bed.
The written plan of care for resident #180 does not provide clear directions to staff, as the use of bed rails is not consistently noted between the different documents that outline the resident's care requirements.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out,(c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Inspector #534 had conducted an interview with a resident #267 when a family member was present. The inspector was told that the resident's assessed preference for thickened tea with meals was not occurring and that the home was aware of the issue. They also told the inspector the reason it was not offered was because the tea needed to be thickened by the staff.

The inspector reviewed resident's #267 annual care conference note. Under the heading "goals and concerns expressed by family", it outlined "decaf tea with meals". The Registered Dietitian concurred on same note that the resident preferred decaf tea with meals rather than between meals. The care plan that the inspector reviewed was inconsistent with the resident's assessed needs and indicated "provide decaf coffee with meals" and all fluids were to be nectar thick in consistency.

During observations of the resident for lunch on two separate days, and breakfast on another day, the inspector noted that the same resident was not offered or given thickened tea. The inspector interviewed staff about their knowledge of the resident's preference for thickened tea with meals. #S-110 told the inspector that resident #267 received regular consistency tea after their meal. According to the staff member, as long as the resident is not eating, they can receive non thickened tea. The staff reported that if the resident is given thickened tea during the meal then they do not eat their food. #S-110 continued to tell the inspector that resident #267 is the only person receiving thickened fluids on the unit. #S-111 told the inspector that the thickened tea is only given

if the resident requests it, and that it is given as a part of every meal.

The inspector reviewed the unit's ordered meal document that outlines resident diet and fluid type, texture of foods, and additional assessed likes or dislikes. The document is used by the cook and serving staff on the unit. #S-111 had provided the document to the inspector. On review of the information for resident #267, it was noted that resident #267's preference for thickened tea to be offered with meals was not outlined on the document. No mention of coffee or tea was evident.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The health care records for resident #203 were reviewed by Inspector #196 for information regarding bladder incontinence. The MDS assessment identified this resident as being frequently incontinent of bladder and that continence products are used. The care plan was reviewed and under the focus of "Toileting" it includes the intervention of "provide supervision with toileting tasks (SPECIFY)" and under the focus of "On prompted voiding program for incontinence as evidenced by frequently incontinent due to: Impaired cognition (dementia)" one of the interventions note "See toileting focus for toileting assistance required". An interview was conducted with #S-109 and it was reported to the inspector that resident #203 is able to self toilet, uses a pull - up and that they require assistance with putting on a new product when needed. According to #S-109, resident #203 self toilets.
The written plan of care does not provide clear directions to staff and others who provide direct care to the resident, specifically information regarding incontinence and need for assistance for product changes.

The licensee has failed to ensure that there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

4. Inspector #196 observed Resident #180, tilted back in a tilt chair and no seat belt was in place. Seat belt observed connected at back of tilt chair and not in place across resident's waist.
Point of Care Kardex as found online was reviewed and under the category of "Bed Mobility N , Safety- Falls, Restraints/PASD N" it included that the resident requires the

use of a Personal Assistive Service Device (PASD) - front closing seatbelt which resident is unable to remove on their own and "Resident uses lap belt for safety & is unable to remove it".
The current care plan as found online in Point Click Care was reviewed and under the focus of "Potential or altered skin integrity, due to decreased ability to move safely, reposition self independently and/or related to: Neurological disease, Restricted mobility" it includes the intervention of "Resident requires the use of a Personal Assistive Service Device (PASD) - front closing seatbelt which they are unable to remove on their own".
Under the focus of "Requires assistance for Mobility characterized by the following functions: positioning, locomotion/ambulation" it includes the intervention of "Resident uses lap belt for safety and is unable to remove it".
Interviews were conducted with #S-109 and #S-108 and it was reported that resident #180 doesn't use a seat belt in the tilt chair.

The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary. [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, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, specifically for residents #180, 267, 203 and to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary, specifically for resident #180, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. Upon record review, Inspector #577 discovered 2 physical altercations that occurred with 2 other residents. On a particular day, resident #265 and resident #500, were found arguing and hitting each other in the hallway. On another day, resident #265 was found on the floor in their room, holding down another resident. Upon staff interview with #S-114, it was discovered that resident #265 had also thrown a cane and a book at resident #500. Inspector #577 conducted a record review of electronic care plan for resident #265, related to responsive behaviors. Plan of care has not been updated to reflect change in behavior, such as throwing a book at a resident and holding a resident down on the floor in their room. Plan of care related to responsive behaviors reads, "Resident will exhibit a decreased number of episodes of wandering and resistance to care, see current medication plan, notify physician/Nurse Practitioner regarding any change in behavior, wanders in resident home area, if strategies are not working, leave resident and re-approach in 15 minutes."

The licensee failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behavior patterns, including wandering, any identified responsive behaviors, any potential behavioral triggers and variations in resident functioning at different times of the day [s. 26. (3) 5.]

2. A previous Critical Incident identifies Resident #501, who fell onto their wheelchair and a bolt from their wheelchair was impaled, approximately 1.5-2 inches. Resident suffered a puncture injury, abrasion to elbow and bump to side of head. Resident transferred to acute care hospital and returned to home after treatment. Resident received 3 sutures to thigh. The following day, two sutures popped and resident was sent back to acute care for treatment. Documentation indicates wound orders from Nurse Practitioner, as follows: Bactroban 2% apply to suture line bid x 10 days remove sutures in 10 days. Upon review of resident #501 care plan, it was discovered that there was not any documentation on altered skin integrity concerning wound. Resident later passed away.

The licensee failed to ensure that plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3). [s. 26. (3) 15.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 5. Mood and behavior patterns, including wandering, any identified responsive behaviors, any potential behavioral triggers and variations in resident functioning at different times of the day, specifically for resident #265 and to ensure that plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 15. Skin condition, including altered skin integrity and foot conditions, specifically for resident #501, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. During the stage one process of the inspection, residents #180, #205 and #251 all reported to inspector #196 that they do not always get a beverage in the morning between breakfast and lunch and also in the afternoon. Outside of the dining room was a sign that read "AM snack at 10:30", "snack 2 pm".
An interview was conducted with #S-113 regarding the dietary service. It was confirmed that there is a beverage pass at 10:00 h, 2:00 h and 7:00 h and snacks at 2:00 h and 7:00 h and the dietary aides prepare the cart and it is left behind the servery counter for the PSW's to give to residents.
Inspector #196 observed the unit from 0950 h to 1157 h, on a particular day, and noted the beverage cart was prepared and behind the servery counter. No morning beverages were observed to be provided to the residents on this particular morning.
Observations of unit on following day started at 1010 h. The beverage cart with coffee carafe, juices on ice, was noted in behind counter of the servery. Beverage cart was not observed to leave the servery. Residents down both corridors were not observed to have received a.m. between breakfast and lunch beverages.

An interview was conducted with #S-115 and it was confirmed that a between meal beverage was not provided to residents on the unit that morning as it was too busy and there was not enough help. In addition, it was reported that often some residents aren't finished in the dining room until 0945hrs and are having beverages then. It was reported by #S-116 that it is too busy in the morning to go around and give beverages to the residents and therefore it is often not done and also confirmed that this was not done this a.m.

The licensee has failed to ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

2. Inspector #577 observed resident #210 not receiving a mid-morning beverage. #S-117 confirmed through a staff interview that morning, that staff will not be giving 10 am beverages today, as they are too busy with morning care. Inspector observed that no beverages were being given to residents that morning.

The licensee failed to ensure that that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (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 each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, specifically for residents #180, 210, 205 and 251, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Resident #301 was observed eating a minced meat sandwich on rye bread, with crusts in place. The dietary reference document as found in the binder at the servery counter, listed a resident as requiring "white bread x crustless bread", "low residue diet", dislikes include "bread whole wheat" and includes "sandwiches". The dietary reference sheets were reviewed with the Nutrition Manager #S-118 and the records identified that this resident is to have white bread as they are on a low residue diet and crustless bread. #S-118 then confirmed this diet with the Registered Dietitian #S-119 who then reported that this was the Speech Language Pathologists orders. #S-118 then provided the resident with white bread minced meat sandwich with crusts removed.
Resident #301 was not provided with the correct diet during the lunch service, despite the dietary records clearly identifying the required type of diet and texture.

The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. [s. 73. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, specifically for resident #301, to be implemented voluntarily.

WN #8: 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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. Inspector #534 reviewed a previous critical incident log of alleged staff to resident abuse and neglect for resident #400 that was reported to have occurred. The inspector interviewed staff #S-101 regarding the incident. #S-101 stated that they were asked by #S-100 for assistance to wash the resident at the start of their day shift. It was documented that the resident was left "soiled with stool" between 0630-0700hrs on a particular day. The home outlined that staff #S-120 had not changed the incontinent brief for the resident the entire night shift (2300-0700 h), was aware that the resident was agitated, confused, and attempting to crawl out of bed, had the posey alarm magnet detached from the resident, was aware that the resident had been incontinent of feces between the time of 0630-0700 h prior to the end of their shift, and failed to address the incontinence or report it to the oncoming staff. The home had classified #S-120 actions as resident neglect.

The inspector noted in the home's written warning to #S-120, the mention of a prior verbal warning for resident neglect related to an incident that had occurred previously. The incident had been brought forward to the home's Resident Services Coordinator and expressed to the home that they did not want the complaint reported to the Ministry. During the previous incident, #S-120 was reported to have exhibited unprofessional conduct by charting with their foot on the wall while a nearby resident sat in a wheelchair with an exposed brief. A safety hazard of spilled juice was reported on the floor. From the home's investigation the staff member was aware of the exposed resident and the spill hazard but did not ensure resident dignity or safety. The incident was never reported to the Ministry and it was a finding of non-compliance.

The licensee has failed to ensure that they made a report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. [s. 104. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they made a report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director, specifically for resident #400, to be implemented voluntarily.

WN #9: 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. Inspector #196 observed the common tv room on one of the units, to be unclean, with flooring grossly soiled in corners and stained in numerous areas, material ripped on arm area of green recliner, debris from plants on floor and a burgundy chair very dusty and soiled on seat surface. On two particular days, Inspector #577 observed the floor and furnishings in common TV room on same unit to be unclean with visible dirt and stains on flooring and furnishings. Burgundy chair remains dirty and dusty, table in common room still dirty with same food debris, flooring dirty and stained. Inspector #577 spoke with staff member #S-121 who reported they are responsible for that floor, and there is a housekeeper for each floor. They are responsible for cleaning the dining rooms floors in the morning and dietary is responsible for cleaning the floors and tables after lunch, cleaning resident rooms, soiled linen room, care cart room, end common room, common rooms on every floor, public bathrooms on each unit and cleaning tub rooms and there is housekeeping 7 days per week.
Inspector #577 observed the wheelchair and lap belt belonging to resident #239, to be soiled with what appeared to be food debris and stains.

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

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. Inspector #577 observed resident #234 to be unshaven, with a lot of facial hair growth on 2 separate days. Resident #234 reports they were not shaven on those days. Inspector reviewed care plan/kardex for resident. Care plan indicates that resident requires one staff assistance for all hygiene needs.

The licensee failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32. [s. 32.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. Inspector #534 had conducted a family interview related to care provided to resident #204 in the home. The family member of the resident raised concerns about the lack of nail care that the resident received. The individual stated that the resident's nails were often overgrown and that nail care was often not provided regularly or frequently in the home. The family member of the resident stated that if they did not personally perform nail care that the resident's nails would become overgrown. The family member of the resident showed the inspector resident # 204's toenails and the inspector confirmed that the resident's toenails were overgrown and untrimmed.

The inspector interviewed several staff members about nail care provided to residents in the home. Staff member #S-106 explained to the inspector that nail care for residents is done on their bath day and additionally any long or dirty nails are trimmed immediately once noticed. Inspector interviewed staff #S-111 about resident nail care in the home.

#S-111 stated that nail care should be on the resident's bath day which is offered twice weekly for the residents in the home. They stated that sometimes nail care is not done because they do not want to wreck the resident's nail polish if the resident has had their nails painted. They went on to state that staff did not have access to nail clippers and that was the main reason why nail care was not being provided to residents in the home. The inspector attempted to find resident nail clippers on the two floors. Inspector #534 could only locate nail clippers as stocked and available for staff use in one out of the four units. In the areas where no clippers were found, both the tub room bins and floor stock boxes were empty. Lack of nail clippers on the various care areas was confirmed to the inspector by staff members #S-111, #S-122, #S-123, #S-106, #S-105 and #S-124.

The home failed to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. [s. 35. (1)]

2. Inspector #534 had noted that resident #218's fingernails were long with visible dirt under the nail when the inspector observed the resident on three separate days. The inspector interviewed several staff members about nail care provided to residents in the home. Staff member #S-106 explained to the inspector that nail care for residents is done on their bath day and additionally any long or dirty nails are trimmed immediately once noticed. Inspector interviewed staff #S-111 about resident nail care in the home. #S-111 stated that nail care should be on the resident's bath day which is offered twice weekly for the residents in the home. They stated that sometimes nail care is not done because they do not want to wreck the resident's nail polish if the resident has had their nails painted. They went on to state that staff did not have access to nail clippers and that was the main reason why nail care was not being provided to residents in the home. The inspector attempted to find resident nail clippers on the two floors. Inspector # 534 could only locate nail clippers as stocked and available for staff use in one out of the four units. In the areas where no clippers were found, both the tub room bins and floor stock boxes were empty. Lack of nail clippers on the various care areas was confirmed to the inspector by staff members #S-111, #S-122, #S-123, #S-106, #S-105 and #S-124.

The licensee has failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

3. Inspector #534 had noted that resident #267's fingernails were long and untrimmed with visible dirt under the nail bed on two separate days.

The inspector interviewed several staff members about nail care provided to residents in the home. Staff number #S-106 explained to the inspector that nail care for residents is done on their bath day and additionally any long or dirty nails are trimmed immediately once noticed. Inspector interviewed staff #S-111 about resident nail care in the home. #S-111 stated that nail care should be on the resident's bath day which is offered twice weekly for the residents in the home. They stated that sometimes nail care is not done because they do not want to wreck the resident's nail polish if the resident has had their nails painted. They went on to state that staff did not have access to nail clippers and that was the main reason why nail care was not being provided to residents in the home. The inspector attempted to find resident nail clippers on two floors. Inspector #534 could only locate nail clippers as stocked and available for staff use in one out of the four units. In the areas where no clippers were found, both the tub room bins and floor stock boxes were empty. Lack of nail clippers on the various care areas was confirmed to the inspector by staff members #S-111, #S-122, #S-123, #S-106, #S-105 and #S-124.

The licensee has failed to ensure that each resident of the home receives fingernail care, including the cutting of fingernails. [s. 35. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In a spa room, on the window sill was a black soiled comb and a used razor, unlabelled. In addition, there was a men's deodorant container, used and unlabelled.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, (a) labeled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. Observed resident #205 at 0950 h, sitting in the common TV room with seat belt grossly soiled. In addition, the resident's top had liquid staining along the front buttons, approx. 10cm X 4cm.
Observed resident #205 again at 1420hrs lying in bed and noted the top to be unchanged and soiled.
The kardex as found in Point of Care notes that the resident "requires extensive assistance for dressing with 1-2 staff assist".

The licensee failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. [s. 40.]

WN #14: 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. An interview with Resident Services Coordinator was conducted by inspector #534, and it was determined that the home did not seek the advice of the Family Council in the development of the home's satisfaction survey. Staff told the inspector that the survey used in the home was a corporate survey from their head office and that the council was not involved in the survey development process.

The licensee has failed to ensure that the advice of the Family Council was sought in developing the survey. [s. 85. (3)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. During interviews with Director of Care and #S-103, it was reported that medications to be destroyed, including vials, packages and pills in medication pouches, are put into a white stericycle plastic pail in the medication room. Two registered staff then witness the medication in the pail, add water and seal the pail and sign the destruction paperwork upon notification that the stericycle company is coming to do a pick up of the containers. The current practice for drug destruction, as confirmed with pharmacist for the home, does not render the medications impossible for use as the vials, pills pouches are placed in the pail unopened. In addition, the pharmacist reported that there has been discussion with other pharmacists in the province regarding this same issue of rendering the medications for drug destruction as impossible for use.

The licensee has failed to ensure that for the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. [s. 136. (6)]

WN #16: 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. Inspector observed a common dining room at 1200 h and #S-125 was seen to put on a hair net onto their head and hand washing was not done prior to reaching over the servery plastic edge and taking a cup of soup to deliver to resident.

On one of the units, the medication cart was observed in the presence of #S-126. In one of the drawers of the medication cart, there were aerochambers used for inhalation type medications. These were lying in the drawer beside other resident's aerochambers and as a result, the mouthpieces were in contact with the mouth pieces of other resident's aerochambers.

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. During the inspection at the home, it had been reported to inspector #534 by #S-111 that staff did not have access to nail clippers to perform resident nail care within the home. During staff interviews about availability of nail clippers, #S-106 told the inspector that they had their own set of nail clippers that they used resident to resident. They stated they sanitized the clippers between residents using the foam hand sanitizer from the wall dispensers.

The licensee has failed to ensure that all staff participate in the implementation of the program. [s. 229. (4)]

Issued on this 5th day of December, 2014

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) :	DEBBIE WARPULA (577), KARI WEAVER (534), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2014_333577_0008
Log No. / Registre no:	S-000206-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 3, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	ROSEVIEW MANOR 99 SHUNIAH STREET, THUNDER BAY, ON, P7A-2Z2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JOANNE LENT

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. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that for residents #400 and #335, 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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Grounds / Motifs :

1. Inspector #534 made note of a foul odor coming from resident #400. On the following day, inspector #534 observed the same odor as the day before but noted the odor to be more severe. #S-101 stated that the odor was coming from a dressed wound and the odor was reported to #S-102. The inspector noted that the resident had the wound covered with a transparent absorbent dressing and a large amount of cloudy, brown drainage had pooled under the transparent dressing. The wound odor could be smelled when the inspector was approximately a meter away from the resident. The inspector asked #S-102 if the dressing had been changed when the personal support worker notified them of the wound odor. They stated the dressing had not been changed because the resident could become combative, would have needed assistance, and they ran out of time. The dressing was not changed on following evening or night shift. #S-102 stated that the wound looked infected and needed to have a culture swab obtained.

The inspector asked the staff member when the last time the dressing had been changed and what wound documentation had been completed. Together, the progress notes for the resident were reviewed. The wound was documented as a long skin tear that occurred as a result of a fall. A wound care referral had been sent after the injury had occurred. Documentation about the wound was found on: June 9, 2014 at 1343 h and 1856 h, June 10, 2014, and June 11, 2014 at 0425 h and 1106 h documenting the wound dressing was dry and intact. As part of the wound care consult, the dietitian assessed the nutritional needs of the resident. The only documented dressing change occurred on June 17, 2014 at 0503 h. Staff #S-102 stated they had changed the dressing on a particular day and had noted an odor to the wound but failed to document the finding or the dressing change. They stated that skin tears are only documented weekly in the progress notes and that orders are entered for skin tears to alert staff to assess and monitor but that this was not done. Staff #S-102 stated that their

program "hasn't been up to par lately". After interviewing staff member, the inspector sought out and brought staff member #S-127 to see the resident's infected left anterior arm wound.

The licensee has failed to ensure that 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. (534)

2. Inspector #577 reviewed the Treatment Observation Record for wound for resident #335. Documentation shows a 12 day gap, where there isn't documentation showing dressing changes. Upon record review, the initial wound assessment from April 14, 2014, indicates a venous wound. Most recent orders written by Wound Care Nurse on April 10, 2014. Inspector spoke with #S-103 about missing documentation. Reports they don't know if dressing changes were done that week.

The licensee failed to ensure that (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2). (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that for residents # 403 and #245 (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and (iv) that complies with manufacturer's instructions for the storage of the drugs;

Grounds / Motifs :

1. During the home's entry tour, inspector #534 found in residents #403 room various improperly stored prescription medications. One jar of ointment in the resident's private bathroom and on the surface top of the resident's dresser an expired (2012) bottle of eye drops and 1 small, white, unlabelled pill in a medicine cup. The items were confirmed with #S-104, who stated the resident did not have orders for medications at the bedside. Additionally, they were unsure where the unattended, small white pill contained in the medicine cup had come from or what it was for.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (i) that is used exclusively for drugs and drug-related supplies, (ii) that is secure and locked, (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and (iv) that complies with manufacturer's instructions for the storage of the drugs; and (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. (534)

2. In a resident room, there was a basket at the beside with two containers of prescription cream inside. There was a tube of cream and a container of cream labelled with resident # 245's name on it. (196)

3. A container of prescription cream was observed on the bedside table of resident #300.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 22, 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 December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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