Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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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
Jun 7, 2016	2016_465621_0003	004909-16	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

JULIE KUORIKOSKI (621), JENNIFER KOSS (616), SHEILA CLARK (617)

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 7, 8, 9, 10, 11, 14, 15, 16, 17, and 18, 2016.

Additional intakes completed during this inspection included:

An intake related to follow up of past due compliance order #001, Long Term Care Homes Act (LTCHA) s.19(1) and compliance order #002, Regulation 79/10 r.71(3);

An intake related to a complaint of alleged resident to resident abuse;

An intake related to a complaint of alleged resident neglect and no RN on duty;

Three intakes related to critical incident's (CI) the home submitted regarding resident to resident abuse;

Eight intakes related to CI's the home submitted regarding staff to resident abuse and neglect; and

Two intakes related to CI's the home submitted regarding resident falls with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Program Manager, Environmental Services Manager (ESM), Nutrition Manager (NM), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

Observations were made of resident care areas, provision of care and services to residents as well as staff to resident and resident interactions. The home's health care records for several residents, and personnel files of a number of staff were reviewed, along with relevant policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **4 VPC(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_380593_0012	616
O.Reg 79/10 s. 71. (3)	CO #002	2015_380593_0012	621

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the written plan of care for each resident, set out the planned care for the resident.

Resident #025 was triggered from the Resident Assessment Instrument Minimum Data Set (RAI MDS) in stage one of the Resident Quality Inspection (RQI) for a specified medical diagnosis.

Inspector #616 reviewed resident #025's RAI MDS Quarterly Assessment dated from September 2015, which indicated a specific disease diagnosis. Progress notes were reviewed and revealed the diagnosed medical condition had occurred in August 2015, with a physician's order for a medication on a specific day in August 2015. Other than a medical diagnosis for the specified condition in the resident's care plan, which was last reviewed in the month of October 2015, there was no care planned focus, goal, or interventions related to the diagnosed medical condition.

During an interview with RPN #104, they reported the resident was known to have had a

specific medical condition, and staff continued to monitor the resident's symptoms. RPN #104 also stated the care plan did not reference the diagnosis of the medical condition, and ongoing monitoring of related symptoms and should have. [s. 6. (1) (a)]

2. A Critical Incident (CI) report was submitted to the Director by the home in the summer of 2015, related to resident to resident abuse between resident #030 and resident #033.

Inspector #616 reviewed the CI which identified as an action taken: that increased monitoring of resident #030 to ensure no further incidents. The Inspector reviewed this resident's care plan, last revised during the month of September 2015, with the ADOC for increased monitoring related to responsive behaviours.

During an interview the ADOC verified that the increased monitoring intervention had not been included in the resident's written plan of care and should have been. [s. 6. (1) (a)]

3. During two days in March 2016, Inspectors #616 and #617 observed a safety device engaged for resident #002. Resident #002 was able to unfasten and re-fasten the device independently when asked to do so.

On a day in March 2016, Inspector #617 interviewed PSW #107 who reported that the device used for resident #002 was a Personal Assistive Device (PASD). PSW #107 reported that they fastened the device on resident #002's chair that morning as part of morning care. PSW #107 stated that they would follow the tasks identified on resident #002's kardex to determine their care provision.

Inspector #617 reviewed resident #002's care plan and kardex which did not indicate the use of a PASD device.

Inspector #617 reviewed the home's policy titled "Personal Assistive Service Devices (PASD)-#LTCJ-30", last revised on December 2015, which indicated the following:
- the care plan would give directions for the application and removal of a device, and other specific needs
-documentation was to be completed every shift on the use of the PASD.

On a specific day in March 2016, Inspector #617 interviewed PSW #107 and they stated that the PASD device used for resident #002 was not identified in their plan of care.

On the same day in March 2016, Inspector #617 interviewed RAI Backup RPN #108 who

stated that the use of the device was not identified in their plan of care. RAI Support RPN #108 reported that the use of the device should have been added to resident #002's plan of care for clear direction to staff and documentation of its use.

Again, on the same day in March 2016, Inspector #617 interviewed DOC #109, who confirmed that resident #002's device used as a PASD was part of the planned care for the resident, but not written in the plan of care prior to a specific day in March 2016. [s. 6. (1) (a)]

4. During two days in March 2016, Inspectors #621 and #617 observed a safety device engaged for resident #003. Resident #003 was able to unfasten and re-fasten the device independently when asked to do so.

On a specific day in March 2016, Inspector #617 interviewed PSW #107, who reported that the device used for resident #003 was a PASD. PSW #107 reported that they fastened the device on resident #003's chair that morning as part of morning care. PSW #107 stated that they would follow the tasks identified on resident #003's kardex to determine their care provision.

Inspector #617 reviewed resident #003’s care plan and kardex which did not indicate the use of a PASD device on their chair.

Inspector #617 reviewed the home's policy titled "Personal Assistive Service Devices (PASD)-#LTCJ-30", last revised December 2015, which indicated the following:
- the care plan would give directions for the application and removal of a device, and other specific needs
-documentation was to be completed every shift on the use of the PASD.

On the same day in March 2016, Inspector #617 interviewed PSW #107 and they stated that the PASD device used for resident #003 was not identified in their plan of care.

During the same day, Inspector #617 interviewed RAI Backup RPN #108 who stated that the use of the device was not identified in their plan of care. RAI Support RPN #108 reported that the use of the device should have been added to resident #003's plan of care for clear direction to staff and documentation of its use.

Again on the same day, Inspector #617 interviewed DOC #109, who confirmed that resident #002's device used as a PASD was part of the planned care for the resident, but

not written in the plan of care prior to a specific day in March 2016. [s. 6. (1) (a)]

5. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Resident #031 had been admitted to the home in early 2016.

Inspector #616 reviewed the Resident Assessment Instrument - Minimum Data Set Admission Assessment (RAI-MDS), dated January 2016, and responsive behaviours had been identified. The Resident Assessment Protocols (RAPS) based on the Mood and Behaviour Patterns assessment, indicated that the resident had been newly admitted to the home and during the observation period they displayed responsive behaviours. It was noted on the assessment that care planning was to be done to reduce frequency and intensity of behaviours.

Inspector #616 reviewed the resident's admission care plan which did not identify any responsive behaviours, nor interventions to reduce the frequency and intensity of those behaviours.

The Inspector reviewed progress notes from the first three months of 2016. As per the documentation in January and February 2016, resident #031 had demonstrated responsive behaviours. The plan in the progress note on a specific day in February 2016, was to update their care plan as needed and monitor for increase in behaviours.

The resident’s care plan was updated to include a Responsive Behaviour focus, 25 days after admission even though, the RAI-MDS Assessment completed on an earlier date in January 2016, identified that this resident had responsive behaviours.

During an interview with the AD and ADOC, they reviewed the progress notes of a specific date in January and February 2016, as well as the admission, and current care plans. The ADOC verified the admission assessment which identified the resident's known responsive behaviours had not been included in their plan of care and should have been. [s. 6. (2)]

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

On a specific date in March 2016, Inspector #621 found resident #022 seated in a wheelchair in their room.

During interviews with PSW's #125, #125, #127 and RPN #104, they all reported that since this resident's fall on a specific date in January 2016, they required a wheelchair for locomotion on and off the unit to activities. Further, they reported that only during a specific activity would the resident use an assistive device with the aid of one staff member.

During an interview with resident #022 on a specific day in March 2016, they reported to Inspector #621 that since their fall in January 2016, which resulted in an injury, they used the assistive device for a specific activity and only when they called a staff person for assistance. Otherwise, resident #022 identified that they used a wheelchair to attend meals and activities.

Inspector #621 reviewed the most recent care plan for resident #022 which indicated under the "Transfers" section that this resident required an assistive device within reach during activities and outings. Similarly, under the "High Risk for Falls" section of the care plan, it was identified that this resident was still able to participate in safe and independent transfers. It was also noted that both the "Transfers" and "High Risk for Falls" sections of resident #022's care plan had not been updated since the third quarter of 2014.

During an interview with the Physiotherapist (PT) and RPN #104, they reported to Inspector #621 that resident #022 no longer went to activities or outings using the assistive device, and that information found in the "Transfers" section of the care plan was no longer reflective of this resident's care needs. Similarly under the "High Risk for Falls" focus, RPN #104 and the PT reported that resident #022 was no longer able to complete independent transfers and confirmed that information in this resident's care plan was not consistent with resident #002's current care needs. Additionally, the PT and RPN #104 verified the interventions listed under the "High Risk for Falls" and "Transfers" foci had not been updated since the autumn of 2014, and should have been.

During an interview with the ADOC, they identified to Inspector #621 that it was the home's expectation that when care needs change, the registered staff would document these changes in the electronic health record and update the care plan. They confirmed that the care plan for resident #022 did not reflect this resident's current care needs

relating to use of assistive devices for activities and outings, or completion of independent transfers. [s. 6. (10) (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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when they were not being supervised by staff.

On three specific days in March 2016, Inspector #617 observed the following doors unlocked, propped open and no staff observed in the area:
- Dirty Utility Room
- Clean Utility Room

During a date in March 2016, Inspector #617 interviewed PSW #111 who confirmed that the doors to the utility rooms were non-residential areas, were open and should have been locked to prevent residents from entering.

On the same day in March 2016, at 1046hrs, Inspector #617 observed a door to another Dirty Utility Room propped open with a chair.

Inspector #617 interviewed Housekeeper #102, who confirmed that the Dirty Utility Room door leading into a non-residential area, was open and should be closed for resident safety. [s. 9. (1) 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 all doors leading to non-residential areas be kept closed and locked when they are not supervised by staff, to be implemented voluntarily.

WN #3: 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 has failed to ensure that the home, furnishings and equipment were kept clean and sanitary and maintained in a safe condition and in a good state of repair.

Inspector #617 reviewed the home's policy titled "Maintenance Services-#ESP-B-50" last revised in February 2015, which indicated that all staff have the responsibility to report and request service on any items in the home requiring repair, replacement and/or adjustment using work requisitions. The Environmental Services Manager (ESM) was to review and prioritize all submitted requisitions, assign the work and ensure that the work was completed.

On a specific date in March 2016, during the initial tour of the home, Inspector #617 observed the following resident areas in the home in disrepair:
- one shower room had one gouge approximately five centimetre square in the floor and one gouge in the corner of the entrance way;
- another shower room had two gouges in the wall on the corner of the entrance way to the shower;
- a third shower room had a worn floor with black dirt embedded in the surface under the shower head;
- one living room had two couches stained with urine and had an odour; and
- the roof was leaking into a waste paper basket in the middle of the hallway on a unit beside the dining room.

Inspector #617 interviewed PSW #122 who reported that the shower had not been operational for the past two years and staff were showering residents in the Spa which had both a shower and tub. Inspector #617 interviewed PSW #132, who reported that another shower had not been operational for the past seven months and staff were

showering residents in the Spa which had both a tub and shower. Inspector #617 interviewed the ESM, who confirmed that both shower rooms had been non-operational for safe resident use and both floors needed to be replaced. The ESM also confirmed that both shower rooms had signage to indicate they were unsafe and not operational.

Inspector #617 interviewed the ESM, who confirmed that the dirty floor in a shower room needed to be steam cleaned and that the mop used by the housekeepers was not efficient in cleaning the embedded dirt. The ESM further reported that staff had not informed the maintenance department of the disrepair and should have.

Inspector #617 interviewed Housekeeper #102 who confirmed that the two couches in a living room were soiled and required cleaning. Inspector #617 interviewed the ESM, who confirmed that the two couches needed to be replaced and that the staff did not inform the maintenance department of the disrepair and should have.

Inspector #617 interviewed the ESM, who confirmed that the roof had been leaking water into the middle of the hallway on one of the units due to the spring thaw for the past three days. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On two specific dates in March 2016, Inspector #616 observed the call bell cord in resident #020's washroom to be too short to reach the toilet from the unit position on the wall.

During an observation of the call bell system in the resident's washroom, PSW #105 confirmed the call bell cord length was too short for the resident to reach from the toilet, and should have been accessible. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the information upon which it was based to the Director.

A Critical Incident (CI) report was submitted by the home to the Director on a specified date in September 2015, which indicated that PSW #118 allegedly abused resident #006, however the incident occurred a day earlier in September 2015.

Inspector #617 reviewed the home's internal investigation which identified two written

notes both dated in September 2015, by RN #112 and RPN #139. The notes indicated a family member of resident #006 was upset and reported that they overheard PSW #118 abuse the resident. RN #112's documentation indicated the DOC was notified of the incident of suspected abuse on a specified date in September 2015, but the DOC did not report it to the Director until one day later.

Inspector #617 reviewed the home's policy titled "Resident Non-Abuse Ontario - #LP-C-20-ON" last revised in September 2014, which indicated that any staff member or person, who became aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information which it is based to the Executive Director of the home or, if unavailable, to the most senior supervisor on shift at that time.

On a specific date in March 2016, Inspector #617 interviewed the Administrator, who explained that the staff were expected to report any CI to the RN on duty, who then was to report to the DOC or ADOC on call, who would then report to the Director. The Administrator confirmed that the report to the Director was one day late, and should have been reported immediately as per home's policy. [s. 24. (1)] (617) [s. 24. (1)]

2. A CI report was submitted to the Director on a specified date in June 2015, regarding suspected abuse of resident #007, however the incident occurred two days earlier.

Inspector #617 reviewed the home's internal investigation which identified resident #007's progress note for a specified date in June 2015, was written by DOC #142. The progress notes indicated that resident #007 reported to Physiotherapist (PT) #143, that PSW #135 was allegedly abusive towards this resident when providing care. The DOC was aware of the suspected abuse of resident #007 on a specific date in June 2015, but did not report it to the Director until two days later.

On a specific date in March 2016, Inspector #617 interviewed the Administrator, who confirmed that the CI report was submitted two days late to the Director and should have been reported immediately as per home's policy. [s. 24. (1)]

3. A CI report was submitted to the Director by the home on a specific date in November 2015, related to suspected neglect of resident #015, however the incident occurred two days earlier.

A review of the home's internal investigation identified resident #015's progress note

dated in early November, described a concern brought forward to the home from the resident's Substitute Decision Maker (SDM) documented by RPN #117. The concern identified neglect of resident #015. The investigation notes also reported communication from RPN #117, dated on the same date in November 2015, to DOC #142, regarding the SDM's reported concern for this resident. The DOC was aware of the suspected neglect of resident #015 on this date, but did not report it to the Director until two days later.

On a specific date in March, 2016, the Administrator was interviewed by Inspector #617 who confirmed that the home determined the incident was neglect and reported it late to the Director. [s. 24. (1)]

4. A CI report submitted to the Director by the home in July 2015, alleged resident to resident abuse between resident #030 and resident #033 that occurred the previous day.

The report indicated that PSW #145 notified RN #146 that while conducting resident checks, the PSW observed resident #030 abusing #033.

Inspector #616 reviewed a progress note that indicated the Assistant Director of Care (ADOC) was notified of the incident by the RN on the evening shift of a specified date in July 2015.

In an interview with the Administrator and the ADOC, the ADOC stated that the incident of resident to resident abuse should have been reported immediately but was not. [s. 24. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred, immediately report the information upon which it was based to the Director, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Falls Intervention Risk Management (FIRM) Program policy and procedure was a) in compliance with and was implemented in accordance with all applicable requirements under the Act; and b) was complied with.

During a review of resident #022's documentation for a fall that occurred on a specific date in January 2016, Inspector #621 could not find a completed neurobiological assessment starting on that date as part of records kept for this resident.

A review of the home's policy titled "Fall Interventions Risk Management (FIRM) Program – LTC-E-60-ON", last revised in March 2014, identified that under the standard operating procedures for post fall management registered nursing staff were to complete the "Neurobiological Flow Sheet – LTC-E-70-05-ON", when a fall was not witnessed or the resident hit their head. This "Neurobiological Flowsheet" was to be completed for 72 hours with resident monitoring.

On a specific date in March 2016, RPN #104 reported to Inspector #621 that as none of the resident's "Neurobiological Flowsheets" were date stamped correctly, they could not identify the completion of this document as required by the home's policy for the fall in January 2016.

During an interview with Inspector #621 on March 17, 2016, the ADOC reported that it was the home's expectation that when a resident had a fall and when required registered staff completed a post fall assessment, including a head injury routine and neurobiological assessment for 72 hours. The ADOC reviewed the post fall documentation for resident #022 relating to the fall for this resident in January 2016, and confirmed that an assessment using the "Neurobiological Flowsheet" for this fall as per home's policy was not completed and should have been. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse was complied with.

A Critical Incident (CI) report was submitted to the Director on June 11, 2015, regarding suspected abuse of resident #007.

Inspector #617 reviewed the home's policy titled "Resident Non-Abuse-#LP-C-20-ON" last revised in September 2014, which indicated that if a staff member has alleged, suspected, or witnessed to have abused and/or neglected a resident, that staff member would be immediately suspended from their duties with pay and required to leave the premises pending investigations.

Inspector #617 reviewed the home's internal investigation which identified resident #007's progress note dated from June 2015, written by DOC #142. The progress notes indicated that resident #007 reported to Physiotherapist (PT) #143, that PSW #135 was abusive towards the resident when they provided care.

A review of the home's investigation was concluded on a specified date in June 2015, that PSW #135 did not abuse resident #007. A review of the PSW #135's scheduled shifts worked during the course of the investigation, indicated that they continued to work their scheduled shifts with resident #007 and was not immediately suspended from their duties with pay or required to leave the premises pending investigation.

On a specific date in March 2016, Inspector #617 interviewed the Administrator who confirmed that PSW #135, was not off with pay pending the investigation, and was only moved to a different unit later in June 2015, after the investigation had been concluded. [s. 20. (1)]

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

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the investigation for suspected abuse of resident #004 was reported to the Director.

A Critical Incident (CI) report was submitted by the home to the Director on a specific date in May 2016. The Substitute Decision Maker (SDM) for resident #004 visited on this date in May 2015, and reported to the registered staff that they noticed evidence of possible abuse.

The Inspector reviewed the home's internal investigation of the incident, which indicated that on the specific date in May 2015, RPN #138 completed an assessment for resident #004 and then reported the incident using the home's internal reporting process. The home's investigation determined that abuse of resident #004 did not occur. A review of the home's CI reports submitted to the Director did not include the results of their investigation.

Inspector reviewed the home's policy titled "Resident Non-Abuse Ontario - #LP-C-20-ON" last revised in September 2014, which indicated that mandatory reporting required a person to make a report to the Director where there was reasonable suspicion that certain incidents occurred. The on-line Mandatory Critical Incident System (MCIS) was to be used to forward the required report.

On a specific date in March 2016, Inspector #617 interviewed the Administrator who confirmed that the home's investigation of this CI was concluded in May 2015, and the home failed to update the Director. [s. 23. (2)]

2. A CI report was submitted by the home to the Director on a specific date in September

2015, which indicated that PSW #118 abused resident #006. Resident #006's family member overheard PSW #118 abuse resident #006. Resident #006's family member reported the incident to the registered staff.

A review of resident #006's care plan last revised on a specific date in September 2015, indicated that resident #006 had exhibited responsive behaviours.

The home conducted their investigation into the CI and on a specific date in September 2015, and concluded that PSW #118 abused the resident. A review of the home's CI reports submitted to the Director did not include the results of their investigation.

On a specific date in March 2016, Inspector #617 interviewed the Administrator, who confirmed that the home's investigation determined that abuse did occur. The conclusion of the investigation occurred in September 2015, and the home failed to update the Director. [s. 23. (2)]

WN #9: 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: 1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's dining and snack service included the communication of the seven-day and daily menus to residents.

Inspector #621 observed on a specific date in March 2016, that the home's seven-day and daily menus as communicated to residents on a resident home area did not identify alternate beverage choices for lunch or dinner meals, and did not incorporate a planned snack menu which specified to residents the alternate beverage choices for morning, afternoon and evening nourishment passes.

During an interview in March 2016, with the Nutrition Manager (NM) #100, a copy of the homes seven-day and daily menus were reviewed with Inspector #621. It was confirmed by NM #100 that the home did not communicate to residents on its seven-day or daily menus the alternate beverage choices for lunch and dinner meals, or the alternate beverage options for snack service as per legislative requirements and should have. [s. 73. (1) 1.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee concerning the care of a resident had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, commenced an immediate investigation.

A written letter of complaint dated on a specific date in December 2015, was received by the Director one day later. This letter was also addressed to the licensee. The complainant reported that resident #029 had displayed responsive behaviours two dates in December 2015. They further alleged in the letter that as a result of the persistence by staff attempting to manage the behaviours, the resident demonstrated increased responsive behaviours. The complainant reiterated their concern of risk to the safety and well being of the other residents to this day.

During an interview with the Administrator and the ADOC, they reported to Inspector #616 that although they were aware of the complaint, they were unable to provide documentation related to an investigation into the reported concerns. They also verified they did not provide a response to the complainant of what the home had done to resolve the complaint. [s. 101. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day, of an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition.

A Critical Incident (CI) report received by the Director on a specific date in January 2016, reported a fall occurring two days earlier, where resident #002 fell and was found by PSW #125.

Inspector #621 reviewed documentation in the progress notes and the CI report for resident #002 which identified that PSW #125 found the resident on the specific date in January 2016, and reported the incident to RPN #144, who called RN #140 on duty to assess the resident. The RN completed an assessment which identified the resident complained of pain. The resident's POA was notified and resident #022 was taken to hospital for further investigations. Documentation further identified that the hospital called the home to confirm the resident #002 had sustained an injury. The incident occurred on a specific date in January 2016, however, it was not reported to the Director until two days later.

During an interview with the ADOC on a specific date in March 2016, it was confirmed to Inspector #621 that the CI was not reported to the Director as per legislative requirements and should have been. [s. 107. (3) 4.]

Issued on this 16th day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE KUORIKOSKI (621), JENNIFER KOSS (616), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_465621_0003
Log No. / Registre no:	004909-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 7, 2016
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 :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall:

a) review and revise the plans of care for resident #025, #003 and #002, to ensure that they set out the planned care for each resident, to enable staff and others who provide direct care to safely care for each resident;

b) develop a process to ensure that the plans of care are clearly communicated to and understood by all staff and others who provide direct care to the residents;

c) develop an auditing process for written plans of care that will identify inaccuracies, so that corrections can be made in order to ensure that the planned care for residents is clearly documented for staff and others who provide direct care to residents; and

d) educate and retrain staff involved in the development of residents' written plans of care, including the risks associated with not providing directions for the planned care of residents to staff and others who provide direct care to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care for each resident, set out the planned care for the resident.

During two days in March 2016, Inspectors #621 and #617 observed a safety device engaged for resident #003. Resident #003 was able to unfasten and re-fasten the device independently when asked to do so.

On a specific day in March 2016, Inspector #617 interviewed PSW #107, who reported that the device used for resident #003 was a PASD. PSW #107 reported that they fastened the device on resident #003's chair that morning as part of morning care. PSW #107 stated that they would follow the tasks identified on resident #003's kardex to determine their care provision.

Inspector #617 reviewed resident #003's care plan and kardex which did not indicate the use of a PASD device on their chair.

Inspector #617 reviewed the home's policy titled "Personal Assistive Service Devices (PASD)-#LTCJ-30", last revised December 2015, which indicated the following:
- the care plan would give directions for the application and removal of a device, and other specific needs
- documentation was to be completed every shift on the use of the PASD.

On the same day in March 2016, Inspector #617 interviewed PSW #107 and they stated that the PASD device used for resident #003 was not identified in their plan of care.

During the same day, Inspector #617 interviewed RAI Backup RPN #108 who stated that the use of the device was not identified in their plan of care. RAI Support RPN #108 reported that the use of the device should have been added to resident #003's plan of care for clear direction to staff and documentation of its use.

Again on the same day, Inspector #617 interviewed DOC #109, who confirmed that resident #003's device used as a PASD was part of the planned care for the resident, but not written in the plan of care prior to a specific day in March 2016. (621)

2. During two days in March 2016, Inspectors #616 and #617 observed a safety device engaged for resident #002. Resident #002 was able to unfasten and re-fasten the device independently when asked to do so.

On a day in March 2016, Inspector #617 interviewed PSW #107 who reported that the device used for resident #002 was a Personal Assistive Device (PASD). PSW #107 reported that they fastened the device on resident #002's chair that morning as part of morning care. PSW #107 stated that they would follow the tasks identified on resident #002's kardex to determine their care provision.

Inspector #617 reviewed resident #002's care plan and kardex which did not indicate the use of a PASD device.

Inspector #617 reviewed the home's policy titled "Personal Assistive Service Devices (PASD)-#LTCJ-30", last revised on December 2015, which indicated the following:
- the care plan would give directions for the application and removal of a device, and other specific needs
-documentation was to be completed every shift on the use of the PASD.

On a specific day in March 2016, Inspector #617 interviewed PSW #107 and they stated that the PASD device used for resident #002 was not identified in their plan of care.

On the same day in March 2016, Inspector #617 interviewed RAI Backup RPN #108 who stated that the use of the device was not identified in their plan of care. RAI Support RPN #108 reported that the use of the device should have been added to resident #002's plan of care for clear direction to staff and documentation of its use.

Again, on the same day in March 2016, Inspector #617 interviewed DOC #109, who confirmed that resident #002's device used as a PASD was part of the planned care for the resident, but not written in the plan of care prior to a specific day in March 2016. (621)

3. A Critical Incident (CI) report was submitted to the Director by the home in the summer of 2015, related to resident to resident abuse between resident #030 and resident #033.

Inspector #616 reviewed the CI which identified as an action taken: that increased monitoring of resident #030 to ensure no further incidents. The Inspector reviewed this resident's care plan, last revised during the month of September 2015, with the ADOC for increased monitoring related to responsive

behaviours.

During an interview the ADOC verified that the increased monitoring intervention had not been included in the resident's written plan of care and should have been. (616)

4. Resident #025 was triggered from the Resident Assessment Instrument Minimum Data Set (RAI MDS) in stage one of the Resident Quality Inspection (RQI) for a specified medical diagnosis.

Inspector #616 reviewed resident #025's RAI MDS Quarterly Assessment dated from September 2015, which indicated a specific disease diagnosis. Progress notes were reviewed and revealed the diagnosed medical condition had occurred in August 2015, with a physician's order for a medication on a specific day in August 2015.

Other than a medical diagnosis for the specified condition in the resident's care plan, which was last reviewed in the month of October 2015, there was no care planned focus, goal, or interventions related to the diagnosed medical condition.

During an interview with RPN #104, they reported the resident was known to have had a specific medical condition, and staff continued to monitor the resident's symptoms. RPN #104 also stated the care plan did not reference the diagnosis of the medical condition, and ongoing monitoring of related symptoms and should have.

The decision to issue this compliance order was based on the scope of this issue which was a pattern of residents' plans of care that did not set out the planned care for the residents; the severity which indicated a potential for actual harm; and the compliance history which identified ongoing non-compliance under s.6 as detailed in the 2015 inspection report #2015_380593_0012, 2014 inspection report #2014_333577_0008 and 2013 inspection report #2013_211106_0006. (621) (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 7th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Kuorikoski

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