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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 14, 2014	2014_258519_0034	T-000089-14	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

SARA VISTA
27 SIMCOE STREET, ELMVALE, ON, L0L-1P0

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

SHERRI GROULX (519), DOROTHY GINTHER (568), SHARON PERRY (155)

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): October 21,22,23,27,28,29,30 / 2014

Critical Incident Log # 270-14 (CIATT Log # TI-T-14-000344) was completed concurrently with this RQI

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care, the Assistant Director of Care, the Recreation Manager, the Medical Director, the Environmental Services Manager, the Revera Regional Educator for Directors of Care, the Food Services Manager, the Dietician, the Cook, four Registered Nurses, two Registered Practical Nurses, and eight Personal Support Workers.

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage area and care provided to residents, reviewed medication records and plans of care for specified residents, reviewed policy and procedures, observed recreational programming, staff interaction with residents and general maintenance and cleaning of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
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
Residents' Council
Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During the observations in Stage 1 of the Resident Quality Inspection (RQI), it was noted that Resident # 40 had one full side rail on the right side raised. The bed system was last evaluated in the year 2012 and the recommendation was to replace the mattress. The mattress was replaced but the bed system has not been re-evaluated to identify potential safety risks since that time with the resident in the bed. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On October 22, 2014 Resident #21, #25, #11, and #26 were observed with one three quarter bed rail in the up position, no mattress keepers at the foot of the bed, and evidence that the mattress was easily slid laterally.

On October 23, 2014 Resident #31 and #36 were observed with one full bed rail in the up position, no mattress keepers at the foot of the bed, and evidence that the mattress was easily slid laterally.

On October 28, 2014 Resident #21, #25, #11, #31, #26 and #36 were observed with

one three-quarter bed rail in the up position, no mattress keepers at the foot of the bed, and evidence that the mattress was easily slid laterally.

The home was not able to provide evidence that where bed rails are used the Resident had been assessed and his or her current bed system evaluated for the use of bed rails. The Environmental Services Manager and Assistant Director of Care confirmed that where bed rails are used there are no ongoing or current assessments of the entrapment zones for residents using bed rails and the bed systems were not evaluated in accordance with evidence-based practices. [s. 15. (1) (a)]

3. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On October 22, 2014 and October 27, 2014 Resident #4 was observed in bed with two quarter bed rails in the up position mid bed. This resident's bed system has not been evaluated for potential safety risks with the resident in that bed.

On October 28, 2014 the Assistant Director of Care and the Environmental Services Manager indicated that where bed rails are used the Resident and his or her current bed system has not been evaluated in accordance with evidence based practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Interview with three staff revealed that Resident #3 frequently makes socially inappropriate comments to staff and visitors. These comments often make staff uncomfortable particularly when providing care.

Review of Point of Care documentation revealed that for over three weeks in October Resident #3 exhibited socially inappropriate/disruptive behavioural symptoms on seven occasions. Progress notes verify the incidents where Resident #3 made socially inappropriate comments to staff.

The plan of care for this Resident does not identify that Resident #3 exhibits socially inappropriate behaviors. The Recreation Manager confirmed that there is no written plan of care for Resident #3 related to these behaviors. [s. 6. (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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #3: 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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #036 was admitted to the home and was noted to be incontinent. Resident #036's Minimum Data Set (MDS) assessment on admission indicated that they were frequently incontinent. Resident #036's MDS assessment(90 days post admission) indicated that they were incontinent all of the time.

The home's policy LTC-E-50, titled Continence Care, states that a 3 day continence assessment is to be completed on admission and/or if there is a change in level of continence. The Assistant Director of Care confirmed that the 3 day continence assessment is a 3 day voiding diary and that it was not done for Resident #036 on admission, or 90 days post admission when there was a change in continence. The Assistant Director of Care stated that it is the expectation that the 3 day voiding diary is done on admission and when there is a change in continence. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy LTC-K-10-ON related to Side Rails, effective October 2013, states that all residents using side rails will be assessed for the need for side rails and the associated risk with the utilization of side rails [LTC-K-10-05-ON Side rail and alternative equipment decision tree].

Resident #036 was observed to use one side rail on their left side.
Resident #054 was observed to use one side rail on their left side.
Resident #040 was observed to use one side rail on their right side.

Record review revealed that resident #036, #040 and #054 were not assessed for the need for side rails and the associated risk with the utilization of side rails as per the home's policy. The Assistant Director Of Care and Executive Director/Director of Care confirmed that the home does not assess the need for side rails and the associated risk with the utilization of side rails as per the home's policy. They stated the Side Rail and Alternative Equipment Decision Tree is not used in the home. [s. 8. (1) (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 that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

One resident in the home revealed that they only have a bath once a week. The resident further indicated that they would prefer to have a tub bath twice a week. Point of Care documentation for this resident indicated that the resident had a tub bath three times in the month of Oct 2014 and a sponge bath five times in the month of Oct 2014.

A Personal Support Worker shared that a resident usually has a sponge bath once a week. They only give a sponge bath when the resident refuses a tub bath. They usually let the registered staff know of the refusal so that it can be documented on Point Click Care because they are unable to record this on their Point of Care documentation.

The Assistant Director of Care confirmed that it is the home's expectation that when a resident refuses a bath it is documented. There was no documentation that the select

resident had refused a tub bath the five times that they were sponge bathed. The home did not ensure that the resident had a bath twice a week by a method of his or her choice. [s. 33. (1)]

2. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A resident in the home revealed that he or she only gets a tub bath once a week. The resident shared that he or she would prefer to have a tub bath more often. Point of Care documentation for this resident indicates that the resident did not have a tub bath during the month of October. There is no documentation in Point of Care or the clinical record to indicate that the resident refused a tub bath. Documentation revealed that this resident had a sponge bath six times in the month of October.

A Personal Support Worker shared that the select resident usually has a tub bath at least once a week. They only give a sponge bath when the resident refuses a tub bath. They usually let the registered staff know of the refusal so that it can be documented because they are unable to record this on their Point of Care documentation.

The Assistant Director of Care confirmed that it is the home's expectation that when a resident refuses a bath it is documented. There was no documentation that the select resident had refused a tub bath six times in the month of October. The home did not ensure that the resident had a bath twice a week by a method of their choice. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Record review revealed that Resident #024 was incontinent had a Foley catheter inserted. There was no assessment of incontinence done using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The Assistant Director of Care confirmed that the home does not use a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Record review revealed that Resident #036 was incontinent on admission and had an increase in incontinence 90 days post admission. There was no assessment of incontinence done using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. The Assistant Director of Care confirmed that the home does not use a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, 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, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident is offered a minimum of, three meals daily.

During the lunch meal service, on October 21, 2014, it was observed that 9 of 59 residents were not present in the dining rooms.

Review of the tray list revealed that 3 trays were ordered. Observations revealed that these trays were given to 3 of the 9 residents that were not in the dining room.

Interview with a Personal Support Worker revealed that 2 of the 6 residents that did not get a tray had refused a tray. During the interview the Personal Support Worker indicated that Resident #002 does not eat certain meals, that Resident #008 ate breakfast and will have supper, that Resident #034 often refuses some meals, and was not sure why resident #043 was not in the dining room.

During interview a registered staff indicated that Resident #002 does not always eat certain meals, Resident #008 had breakfast so will have supper, that Resident #034

was sleeping and would get up for supper, and that Resident #043 was sleeping and would be given something on the afternoon snack cart.

Interview with a second registered staff was done and they indicated that Resident #002 should have been given a tray if they did not come to the dining room, that Resident #008 usually only eats one meal a day and are given extra supplements and fluids on the snack cart, that Resident #034 skips a lot of meals but family is aware, and that Resident #043 has a medical condition and will often not eat.

During the lunch meal service, on October 29, 2014, it was observed that 10 of 55 residents were not present in the dining rooms. Five of the 10 residents not in the dining rooms received tray service.

During the lunch meal service, on October 30, 2014, 14 residents were observed in their rooms. Seven trays were prepared and given to residents in their rooms. Resident #034 was observed by Inspector #568 in their room sitting on side of bed. Resident #034 told Inspector #568 that they were waiting for their lunch. Resident #034 was not prepared a tray and when observed again by Inspector #568 they were laying in bed and told Inspector that they did not get lunch.

Review of the tray list revealed that Resident #034 was not prepared a tray. Interview with registered staff revealed that if residents refuse a meal it is noted on the shift report sheet. The shift report sheet was reviewed with the registered staff and it indicated that Resident #034 refused lunch. It only indicted that another 3 residents refused the noon meal.

Interview with the Food Service Manager revealed that trays are prepared for those residents placed on the tray list and that it is the expectation that all residents are offered a minimum of three meals daily. [s. 71. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of, three meals daily, 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:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents eating in locations other than dining areas are monitored during meals.

On three dates in October, a resident was observed to have a meal tray delivered to their room. Observations made during these meals revealed that no staff returned to the room of the resident and the resident did not eat any of the meal on these dates observed. Staff returned at the end of the meal to remove the tray from the resident's room.

This resident was not monitored according to their plan of care.

During an interview with registered staff regarding how residents are monitored when receiving meals in their rooms, they stated that their hope was that the Personal Support Worker that delivered the meal would return to check on the residents.

Observations made by the Inspector confirmed that this does not occur. [s. 73. (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 residents eating in locations other than dining areas are monitored during meals,, to be implemented voluntarily.

WN #8: 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. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

During this Resident Quality Inspection (RQI) it was noted that the vaccine fridge was kept in the Assistant Director of Care/Staff Educator office. The vaccine fridge contained Pneumovax, Flu vaccine, and TD absorb. This office was noted have the door propped open during the inspection and office was unattended. The Recreation Manager confirmed that the door is rarely closed as the photocopier is kept in the office and is needed. The Recreation Manager confirmed that the vaccine fridge was not secure and locked. [s. 129. (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 drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #9: 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:
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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted:
Every resident has the right to,
11. 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.

On October 21, 2014 during review of the home's binder entitled "Public Information" it was noted that the binder contained the Licensee copy of inspection report number 2012_103193_0002 dated October 18, 2012. It was noted that the resident inventory list was attached to the report.

On October 21, 2014 a second review of the home's binder entitled "Public Information" it was noted that the binder now contained the Licensee copy of inspection report number 2013_109153_0026 dated November 1, 2013. It was noted that the resident inventory list was attached to the report.

This was brought to the attention of the Executive Director/Director of Care who stated that it is nice to know that these are not to be posted. The Inspector showed the Executive Director/Director of Care the fax cover sheet that was attached to the report that read "Please do not post this Inspection Report-Licensee Copy in the home. This report must remain confidential as it may contain Personal Health or other information that is protected".

Both reports were removed from the binder and handed to the Executive Director/Director of Care by the Inspector. [s. 3. (1) 11. iv.]

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

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that menu substitutions are communicated to residents.

On October 21, 2014 at the noon meal the posted desserts were Strawberries/Whipped Topping or Cheesecake. There were no strawberries, so mixed berries (blueberries and raspberries) were served. Staff confirmed that this menu substitution was not communicated prior to dessert being served. [s. 72. (2) (f)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee failed to ensure that that copies of the inspection reports from the past two years for the long-term care home were posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

On October 21, 2014 during the initial tour of the home the Inspector was unable to locate the posting of the inspection reports for the past two years.

When the Executive Director/Director of Care was asked regarding where the inspection reports were posted she stated that there was a short inspection done in 2013 but there were no findings. The Executive Director/Director of Care was informed that there was an inspection done in the home October 23, 2013 and that there were findings and asked where the reports are to be posted. The Executive Director/Director of Care took the Inspector to the board between the front entrance door and gave the Inspector the binder titled "Public Information". The binder did not contain a copy of the October 23, 2014 inspection report, inspection number 2013_109153_0026. This was confirmed by the Executive Director/Director of Care. [s. 79. (3) (k)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 225. Posting of information

Specifically failed to comply with the following:

s. 225. (1) For the purposes of clause 79 (3) (q) of the Act, every licensee of a long-term care home shall ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
1. The fundamental principle set out in section 1 of the Act. O. Reg. 79/10, s. 225 (1).
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101 (3) of the Act. O. Reg. 79/10, s. 225 (1).
3. The most recent audited report provided for in clause 243 (1) (a). O. Reg. 79/10, s. 225 (1).
4. The Ministry's toll-free telephone number for making complaints about homes and its hours of service. O. Reg. 79/10, s. 225 (1).
5. Together with the explanation required under clause 79 (3) (d) of the Act, the name and contact information of the Director to whom a mandatory report shall be made under section 24 of the Act. O. Reg. 79/10, s. 225 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the information required to be posted in the home and communicated to residents under section 79 of the Act includes the following:
2. The home's licence or approval, including any conditions or amendments, other than conditions that are imposed under the regulations or the conditions under subsection 101(3) of the Act.

On October 21, 2014 during the initial tour of the home it was noted that the posted Long-Term Care Home License for Sara Vista had the expiry date of July 6, 2009.

When the Executive Director/Director of Care was asked and shown that the posted Long-Term Care Home License had expired, she stated that the current one was in the Administrative Office. The Inspector entered the Administrative Office with the Executive Director/Director of Care and she showed the Inspector the home's membership certificate with the Ontario Long Term Care Association. The Inspector advised the Executive Director/Director of Care that that was not the Long-Term Care Home License. By end of the day October 21, 2014 the home had obtained a copy of the current Long-Term Care Home License that expires June 30, 2025 as it had been requested by the Inspector. [s. 225. (1) 2.]

Issued on this 18th day of November, 2014

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

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) :	SHERRI GROULX (519), DOROTHY GINTHER (568), SHARON PERRY (155)
Inspection No. / No de l'inspection :	2014_258519_0034
Log No. / Registre no:	T-000089-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 14, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	SARA VISTA 27 SIMCOE STREET, ELMVALE, ON, L0L-1P0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Belinda Robitaille

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

Order / Ordre :

The licensee must ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On October 22, 2014 and October 27, 2014 a resident was observed in bed with two quarter bed rails in the up position mid bed. The resident was not assessed in the bed to minimize risk to the resident.

On October 28, 2014 the Assistant Director of Care and the Environmental Services Manager indicated that where bed rails are used the Resident and his or her current bed system has not been evaluated in accordance with evidence based practices to minimize risk to the resident. (568)

2. The licensee has failed to ensure that where bed rails are used, the resident

has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

On October 22, 2014 three residents were observed with one three quarter bed rail in the up position, no mattress keepers at the foot of the bed and evidence that the mattress was easily slid laterally.

On October 23, 2014 two residents were observed with one full bed rail in the up position, no mattress keepers at the foot of the bed and evidence that the mattress was easily slid laterally.

On October 28, 2014 six residents were observed with one three-quarter bed rail in the up position, no mattress keepers at the foot of the bed and evidence that the mattress was easily slid laterally.

The Home was not able to provide evidence that where bed rails are used the Resident had been assessed and his or her current bed system evaluated for the use of bed rails. The Environmental Services Manager and Assistant Director of Care confirmed that where bed rails are used there are no ongoing or current assessments of the entrapment zones for residents using bed rails and the bed systems were not evaluated in accordance with evidence-based practices. (568)

3. The licensee has failed to ensure that where bed rails are used, has the resident been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During the observations in Stage 1 of the Resident Quality Inspection (RQI), it was noted that one resident had one full side rail raised on the right side of their bed.

The home had the bed systems evaluated in the year 2012 and this resident's bed had failed the evaluation for bed entrapment. The recommendation was to replace the mattress. The mattress was replaced but the bed system was not re-evaluated with the resident in the bed for risk to the resident. (519)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 12, 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 14th day of November, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sherri Groulx

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