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

Division des foyers de soins de longue durée
Inspection de sions 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
Mar 8, 2016	2016_267528_0003	002232-16	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

TELFER PLACE
245 GRAND RIVER STREET NORTH PARIS ON N3L 3V8

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

CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 27, 28, February 2, 3, 4, 5, 8, 9, 2016.

This inspection was completed concurrently with Complaint Inspection Log #'s 030564-15 related to staffing medication administration infection prevention and control, dietary, therapy services, 000822-16 medication administration, 002215-16 staffing levels; Critical Incident Report Log's #'s 031458-15 fall, 027502-15 responsive behaviours; and Follow-ups Log #'s 008199-15, 008200-15, 008201-15.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Directors of Care (DOC), Program Aide, Resident Assessment Instrument (RAI) Coordinator/Assistant Director of Care (ADOC), Food Service Manager (FSM), Registered Dietitian (RD), Environmental Services Manager (ESM), Physiotherapist (PT), physiotherapy assistant (PTA), Regional Manager of Clinical Services, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), cook, dietary aides, residents and families.

The inspectors also toured the home, observed the provision of care and services, reviewed documents, including but not limited to: menus, production sheets, staffing schedules, policies and procedures, meeting minutes, clinical health records, and log reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

Findings/Faits saillants :

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

In February 2016, resident #007 identified that they had a partial denture. However, review of the written plan of care and Kardex did not indicate an oral care focus, goal or

intervention. Review of the Point of Care (POC) documentation between January and February 2016, revealed that oral hygiene was performed twice daily. Interview with PSW #122 stated that the resident brushed their own teeth, was not aware they had a partial plate and the Kardex did not address their oral care needs. Interview with registered staff #108 confirmed there was not a written plan of care that set out the planned care for the resident related to oral hygiene. (581) [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

Resident #006's plan of care indicated they were to receive 250 mililitres (mL) of nutritional supplement at breakfast, lunch and supper and also directed staff to provide 100 mL of the same supplement at breakfast. The FSM confirmed the resident was to receive 100 mL of the supplement at breakfast and the plan of care did not set out clear direction to staff and others who provided direct care to the resident, regarding the amount of supplement the resident was to receive at breakfast. (585) [s. 6. (1) (c)]

3. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #010's plan of care identified that they were a high nutritional risk. The resident and their family reported their care requirements included types of food to avoid. Dietary staff #115 reported they were aware of the resident's identified needs since their admission in 2013. Review of the resident's clinical record did not reveal any denotation of their needs until 2016, which was confirmed by the FSM (585) [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A review of the Minimum Data Set (MDS) assessment completed in January 2016, indicated resident #007 had some or all natural teeth lost and did not have or did not use dentures or a partial plate. However, in October 2015, the resident was noted to have dentures and/or a removable bridge and some or all natural teeth lost and did not have or use a partial plate. Review of the resident assessment protocol (RAP) from October 2015 and January 2016 stated the resident had some of their natural teeth and some were lost and they did not have dentures or a partial plate. In February 2016, the resident stated that they had a partial upper plate. Interview with registered staff #108

and PSW #122 stated the resident only had their own teeth with some missing and were unaware the resident had a partial plate. Registered staff #108 stated the resident had a partial plate and confirmed that the assessments were not consistent with each other related to the resident's dental and oral status. (581) [s. 6. (4) (a)]

5. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A. Resident #004's plan of care stated they were at high nutritional risk and interventions in their plan included but were not limited to providing nutritional supplements at meals, thickened fluids, remain upright after eating and record weights twice a month.

Review of the resident's medication administration record (MAR) and observations during meals and snacks revealed the resident did not receive their nutritional supplements as indicated in their plan of care:

i. In November 2015, December 2015 and January 2016, the MAR indicated they did not always receive nutritional supplements as they were unavailable. On February 2, 2016, during a supper observation, they did not receive their nutritional interventions as the home was unable to thicken it to the appropriate consistency, as confirmed by registered staff #112.

ii. On February 4, 2016, during a morning nourishment observation, the resident did not receive their nutritional intervention as confirmed PSW #121 and registered staff #105.

iii. On February 2, 2016, during a lunch observation, the resident received nutritional intervention that was not thickened as per the resident's plan of care. The FSM confirmed the beverage was not the appropriate thickness. Following confirmation of the inappropriate fluid consistency, registered staff #108 was observed and confirmed they added an additional scoop of thickener to the partially consumed beverage and provided it back to the resident, not following direction as indicated on the thickener container.

v. On February 2, 2016, after lunch and supper, the resident was observed tilted back and unsupervised 10 minutes after eating. Registered staff #108 stated the resident was to remain monitored and upright 30 minutes post meals.

vi. In November and December 2015, the resident was not weighed twice a month, as confirmed by the RD.

B. Resident #006's plan of care stated they were at high nutritional risk. Their plan of care stated they were to provide interventions with foods including and thickened fluids and specific nutritional intervention at breakfast.

i. On February 2, 2016, during a supper observation, the resident was provided a meal that did not include additional interventions as confirmed by dietary staff #116. Interview with the RD confirmed the resident was to receive the additional interventions.

ii. On February 2, 2016, during supper, the resident received a beverage that appeared to be a consistency, thinner than required in the plan of care, as confirmed by PSW #110.

iii. Review of the resident's medication administration record (MAR) from December 2015 to February 2016, revealed they did not always receive their nutritional supplement at breakfast, as it was unavailable. Registered staff #112 confirmed at times, the supplement was not available in the home and therefore not provided to the resident. (585) [s. 6. (7)]

6. The licensee failed to ensure that the resident was assessed and the plan 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 was no longer necessary.

A. The written plan of care for resident #005 indicated that they were transferred and toileted with two person assistance and a gait belt for all transfers. Interview with PSW #109 stated that the resident was transferred with the sit to stand lift to get in and out of bed, was no longer toileted. Interview with registered staff #106 stated they were transferred with the sit to stand lift and not toileted and confirmed that the written plan of care was not updated when their transferring and toileting needs.

B. In October 2015, resident #060 fell resulting in a significant change in status. Review of the progress revealed that the resident was to be on bed rest and required a bed pan for toileting and required additional interventions for resident safety. In November 2015, new orders were received for the resident to use a bed side commode for toileting. Review of the written plan of care noted that the interventions for resident safety was not updated when the resident's care needs changed. Interview with registered staff #107 confirmed that the plan of care was not revised until weeks after the resident fell and their care needs changed.

C. In October 2015, resident 060 fell and sustained an injury. Review of the progress notes indicated that the resident used one bed rail raised when in bed for safety. Review of the written plan of care noted that the bed rail was not assessed as a personal assistive service device (PASD) and was not updated until the following month. Interview with registered staff #107 confirmed that the written plan of care was not revised when their care needs changed related to the use of bed rails. (581)

D. Review of the MDS assessments completed in October 2015, July 2015, and January 2016, for resident #006 indicated that the resident was bedfast all or most of the time. During the course of this inspection the resident was observed in the dining room for one meal per day. Review of the written plan of care indicated that the resident requested to be up only for meals. Interview with PSW #124 and registered staff #108 stated the resident usually gets up for one meal a day and spent the rest of the day in bed. . Interview with registered staff #107 stated the resident was bedfast most of the time and that the written plan of care was not revised related to their preference to stay in bed and to get up for only one meal a day. (581) [s.
6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 resident is assessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee failed to ensure that residents with a change of 7.5 per cent of body weight, or more, over three months and a change of 10 per cent of body weight, or more, over 6 months, were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

A. Resident #004's plan of care indicated they were at high nutritional risk, as confirmed by the RD.

In November 2015, the resident had a weight change of 23.7 per cent over six months and 26.1 per cent over two months, as indicated in their weight records. Review of their clinical record revealed the RD completed an assessment in November 2015, and implemented interventions to promote caloric, fluid and fibre intake and to weigh the resident twice a month.

In December 2015, the resident was identified to have a weight change of 9.4 per cent over one month and 19.2 per cent over three months. In January 2016, they were identified to have a weight change of 9.9 per cent over two months and 18.8 per cent over six months. No information was noted regarding a three month change as no weight was recorded in October 2015. In February 2016, the resident triggered for a weight change of 20.5 per cent over one month. In a review of the resident's clinical record, no interdisciplinary assessments were conducted regarding the continued triggered weight changes in December 2015, January 2016 and February 2016, weights were not measured and recorded twice a month, and no evaluation of the actions taken in

November 2015 occurred, which was confirmed by the RD.

B. Resident #006's plan of care indicated they were high nutritional risk.

In October 2015, the resident was identified as having a weight change of 7.3 per cent over one month and 10.2 per cent over two months, as indicated in their weight records. Review of their clinical record revealed the RD completed assessments in October 2015, and implemented interventions to promote food and fluid intake.

In November 2015, the resident has weight change of 10.2 per cent over three months and 11.2 per cent over six months. In December 2015, the resident had a change of 8.4 per cent over three months. In a review of the resident's clinical record, no interdisciplinary assessments were conducted regarding the continued triggered weight changes in November and December 2015, which was confirmed by the RD.

C. In October 2015, resident #007 experienced a weight change of 5.2 per cent over one month, 11.5 per cent over three months, and 10 per cent over six months, as indicated in their weight records. Review of their clinical record revealed the RD completed an assessment of the resident in October 2015 and implemented nutrition interventions to promote caloric intake and prevent weight loss.

In November 2015, the resident's weight record noted they experienced a weight change of 10.7 per cent over three months and 11.4 per cent over six months. In December 2015, records noted a weight loss of 12.1 per cent over six months. In a review of the resident's clinical record, no interdisciplinary assessment was conducted regarding the continued triggered weight changes over three and six months, as identified in November and December 2015, nor was there a noted evaluation of the actions taken in October 2015, which was confirmed by the RD.

D. The home's policy, "Height Measurement and Weight Management – Index: TC-G-60" revised June 2014, stated the weight record will be reviewed monthly, a nutrition referral to the RD will be completed and information documented in the interdisciplinary progress notes for weight variances in residents as outlined under O. Regulation 69. The RD confirmed they did not receive referrals for the changes identified for resident #004, #006 and #007, nor were interdisciplinary progress notes made regarding the variances. (585) [s. 69.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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,
(b) a three-day supply of nutritional supplements, enteral or parenteral formulas as applicable; O. Reg. 79/10, s. 72 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the food production system at a minimum, provided for a three-day supply of nutritional supplements, as applicable.

A. Resident #004's plan of care indicated they were to receive nutritional interventions at meal times. Review of the resident's medication administration record (MAR) from November 2015 to February 2016, revealed the resident did not receive each supplement 11 times, as documentation indicated the supplements were unavailable.

B. Resident #006's plan of care stated they were to receive a nutritional supplement at breakfast. Review of the resident's MAR from December 2015 to February 2016, revealed that the resident did not receive their hyfibre on five occasions, as documentation indicated it was unavailable.

Interview with registered staff #112 who administered supplements reported there were times when they experienced supplements unavailable in the home. Interview with the FSM confirmed at times, the home did not consistently maintain a three-day supply of the hyfibre and boost fruit juice supplements. [s. 72. (2) (b)]

2. The licensee failed to ensure that food and fluids were prepared, stored, and served using methods which preserved taste, nutritive value, appearance and food quality.

A. In January 2016, a complaint was submitted to the Ministry of Health and Long-Term Care regarding concerns related to the quality of food served to residents at breakfast, as it was reported that residents were not receiving their meals until after 1000 hours.

B. On an unidentified day in February 2016, pureed eggs and bread were observed in the kitchen in the steam table at 0930 hours. Interview with dietary staff #133 reported the pureed eggs and toast were prepared at 0815 hours. Pureed egg was sampled and noted containing clumps and required chewing to swallow. Pureed toast was sampled and sticky, requiring chewing to swallow. Oatmeal appeared overcooked and gummy. Dietary staff #133 confirmed the textures were not acceptable, and after 0930 hours, breakfast items were typically thrown out.

At 0955 hours, a prepared tray for resident #101 was observed sitting on a cart in dining room that contained pureed egg, toast and oatmeal, milk and juice. Interview with dietary staff #115 reported the tray was prepared between 0920 and 0930 hours, as it was to be delivered to the resident at that time. At 1015 hours, the tray was still in the dining room, with no staff available to provide it as reported by PSW #100. After 1015 hours, the resident received a breakfast tray.

C. On an unidentified day in January 2016, during lunch, broccoli served appeared green/brown and crumbly.

D. On an unidentifieid day in February 2016, during supper, asparagus served appeared overcooked and stringy. (585) [s. 72. (3) (a)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 food production system in a minimum, provided for a three-day supply of nutritional supplements, as applicable, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that no person administered a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On December 28, 2015, during evening medication pass, RPN #126 dispensed medications from the medication cart according to the electronic medication administration record (eMARS), and then gave them to the ED to administer to the residents. Interview with staff #128 confirmed that the ED had administered medications to more than one resident on the identified day. Review of the home's 2015 Staffing Plan Evaluation, which documented that the ED carried medications to residents after they had been dispensed by RPN #126, including one insulin. Interview with the ED on February 8, 2016, confirmed that on December 28, 2015, RPN #126 dispensed medications and then the ED carried the medications to the resident and administered the medications, including one subcutaneous insulin. The ED confirmed that they were not registered under the College of Nurses. [s. 131. (3)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system put in place was complied with.

The home's procedure, "Interdisciplinary Hydration Strategies", revised December 8, 2014, stated that on the third day of not meeting daily fluid target, the following strategies would be offered to the resident: referral to the registered dietitian with completed dehydration assessment, offer fluids throughout shift, document approaches and refusals, care plan updated, and progress note completed.

A. Resident #004's plan of care indicated they had inadequate fluid intake as evidenced by not meeting their daily fluid requirements and to implement the home's hydration program/protocol: Telfer hydration strategies.

Review of the resident's fluid intake record from January to February 2016, revealed they did not meet their requirement 33 out of 35 days. During the review period, staff did not complete the assessment on the third day of not meeting their goal. Assessments were completed five times between four to eleven days after they failed to meet their target. Registered staff #107 confirmed the home did not follow their interdisciplinary hydration strategies procedure for resident #006.

B. Resident #006's plan of care indicated they had potential for inadequate fluid intake as evidenced by frequently not meeting 80 per cent (%) of fluid requirements. The plan indicated when 80% of fluid requirement was not met, to implement Telfer's nursing hydration strategies.
Review of the resident's fluid intake record from January to February 2016, revealed they did not meet 80% their fluid requirement 33 out of 35 days during the review period, during which time, staff did not complete the assessment on the third day of not meeting their goal on four separate occaisions. Registered staff #107 confirmed the home did not follow their interdisciplinary hydration strategies procedure for resident #006. (585) [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 any plan, policy, protocol, procedure, strategy or system put into place is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulation.

A. The Family Satisfaction Survey from August 2015, identified that only 23.5 percent (%) of respondents felt there was enough staff to meet the residents' needs.

B. Observed the provision of care from approximately 0745 hours, on February 2, 2016. Staff were observed to work consistently without interruption of breaks or to deal with acute situations. Interview with PSW #113 confirmed that the PSWs were fully staffed for day shift.

i. At 0800 hours, six residents were observed in the small dining room dietary staff and one PSW assisted in small dining room to begin serving breakfast. During that time four PSWs continued to provide morning care to residents, two PSWs down each hallway.
iii. At 0820 hours, dietary aide #115 was observed transporting four residents from lounge and common resident area to the dining room.
iv. At 0830 hours, five residents remained in large dining room with food and/or drinks served. Dietary aide was observed to assist residents into the dining room again at 0830 hours and 0840 hours. The large dining room was not being monitored by nursing staff until approximately 0855 hours.
v. Interview with dietary aide #115 who reported they were escorting residents into the dining room because the PSW staff were busy trying to get all the residents up out of bed, and they otherwise the residents would not be in the dining room.
vi. Review of Dietary Aide position summaries and job routines for all shifts, did not include the portering residents to and from dining room.
viii. At approximately 1114 hours, the Maple Hallway tub room call bell was initiated. Two PSWs assigned to Maple were providing care and services to residents; one PSW staff was observed attending to snack cart and the second was involved in a care conference. At 1120 hours, housekeeping staff was observed entering the Maple Hallway tub room and call bell was shut off. Interview with bath PSW #122 identified that the resident being bathed required two staff assistance using a mechanical lift. The PSW had sought out housekeeping staff because the resident was cold after their bath waiting for a second PSW to assist.
ix. Interview with ED on February 8, 2016, and review of staffing training records, confirmed that housekeeper #129, had received training within relation to safe and lift transfer for emergency situation such as evacuation and pandemic occurrences and not on a "routine basis".
x. At 1130 hours, interview with two PSWs down Maple Hallway who identified that they had not had time to take any scheduled breaks.

C. Scheduled Meal and Snack times provided by the ED to the RQI Team included breakfast in the small dining room at 0800 hours, and the large dining room at 0815 hours. Scheduled snack cart was to start at 1015 hours, followed by lunch at 1200 hours. Resident Council approved meal and snack times in 2015.

D. The POC documentation and "LTC 24 hour report" identified that resident #099 did not receive a scheduled bath in February 2016, and there was no documentation to support that a make up bath was completed, nor did the documentation support that the resident refused, which was confirmed by registered staff #107 on February 9, 2016.

E. On February 3, 2016, from approximately 1100 hours, provision of care was monitored. At 1135 hours, resident #001 was assisted the toilet by one staff. At approximately 1140 hours, the resident pressed the call bell for assistance. After eight minutes, the resident was assisted off the toilet. Interview with the resident at approximately 1200 hours, who stated that the home did not have enough staff and they had to wait too long for assistance off the toilet.

F. On an unidentified day in February 2016, at approximately 1430 hours, PSW #104 identified that resident #002 had not receive their scheduled bath, as they did not have enough time to bathe the resident. Review of Point of Care documentation and "LTC 24 hour report" identified that resident #002's bath was not made up on the following two days before their next scheduled bath. Confirmed with registered staff #107 that PSW staff worked short two out of three days.

G. On February 4, 2016, at approximately 0830 hours, residents #081, #093 and #096, were observed laying in bed on a mechanical lift sling fully clothed, including shoes. The three residents were not observed transferred to their chairs until approximately 0915 hours and transported to the large dining room for breakfast until 0930 and 0935 hours. Interview with PSW #124 identified that resident #096's care was completed first and was in bed ready for transfer by 0700 hours. Resident #093 was next, morning care was completed and was ready to be transferred out of bed before 0730 hours. Lastly, resident #081 was provided morning care and ready to be transferred out of bed around 0800 hours. The PSW also revealed that all three residents required a mechanical lift with two staff assistance, and therefore, a second PSW was not available until after 0915 hours to mechanically lift the residents out of bed.

H. On February 5, 2016, at 0830 hours, RPN #130 confirmed that the home was working short one PSW that morning, and a replacement PSW was on the way.
i. At 0845 hours, resident #002 was noted to be awake and laying in bed. Resident was not assisted with morning care until approximately 0930 hours, and as a result, was not assisted to the dining room until 0945 hours. Interview with resident #002, on the way to the dining room, who stated that they were hungry and had to wait too long for breakfast.

Interview with PSW #121 confirmed that since the bath PSW did not come in, they had to assist one resident with a bath before starting morning care, which delayed getting resident #002 out of bed.
ii. From 1045 hours to 1130 hours, morning beverage cart was observed. Interviews with PSW #120 and #121 confirmed they had not received any scheduled breaks. At 1130 hours, resident #010 was overheard stating that it was "ridiculous" the snack cart was still out.
iii. Interview with PSW #120 and #121 at 1200 hours, identified that they had not had any scheduled breaks in order to try and meet all residents' needs; and stated that it was a regular occurrence.

I. On February 4, 2016, at approximately 0940 hours, a prepared tray for resident #101 was observed sitting on a cart in dining room that contained puree egg, toast and oatmeal, milk and juice, the oatmeal appeared overcooked and gummy. At 0955 hours, the prepared tray remained on the cart. Interview with dietary staff #115 reported the tray was prepared between 0920 and 0930 hours, as it was to be delivered to the resident at that time. At 1015 hours, the tray was still in the dining room, with no staff available to provide it as reported by PSW #100.

J. Review of POC documentation and "LTC 24 hour report" identified that resident #081 received two baths in a two week period. Review of home's bathing schedule and POC documentation identified that the resident did not have two scheduled baths. The home's PSW schedule identified that PSW staff worked short on the days the resident was scheduled to be bathed, as confirmed by registered staff #107. The resident was not provided the minimum bathing requirements.

K. In October 2015 an altercation had occurred between resident #080 and resident #095. Review of the plans of care for both residents, identified that they were both cognitively impaired. The plan of care for resident #080 revealed that the resident had a history of responsive behaviours that increased in the evenings. The progress notes for resident #080 also revealed that the resident displayed behaviours that morning, that required staff interventions. Review of the "PSW Schedule" identified that on the evening of the unidentified day in October 2015, the home was working short two PSWs. Interview with registered staff #108 and PSW #124 confirmed that the resident displayed responsive behaviours that morning and had a history of altercation with resident #095. Interview with PSW#132 confirmed that they were working short that day and PSW staff were unable to prevent the altercation as they were providing care and did not witness it.

L. Review of the home's "PSW Schedule" from July to October 2015. Shifts were highlighted by registered staff #107 and DOC #2 that the home worked short. Specifically, the staffing plan to find replacement staff was followed, but the home was unable to fill positions.
i. In July 2015, the home worked short 36 hours on day shift and 40 hours on evening shift
ii. In August 2015, the home worked short 37 hours on day shift and 45 hours on evening shift
iii. In September 2015, the home worked short 32 hours on day shift and 40 hours on evening shift
iv. In October 2015, the home worked short 52 hours on day shift and 32.5 hours on evening shift (528) [s. 31. (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 the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and the Regulation, to be implemented voluntarily.

WN #7: 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 failed to ensure that each resident of the home was 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.

A. Review of POC documentation and "LTC 24 hour report" identified that resident #081 received two baths in a two week period. Review of the home's bathing schedule identified that the resident was scheduled to receive baths on two unidentified dates. Review of the PSW Schedule revealed that PSW staff were working short on both days as confirmed by the ED and staff #107, and make up baths were not completed. The resident was not provided the minimum bathing requirements.

B. During the course of the inspection, at the end of a day shift, PSW #104 identified that resident #002 did not receive their scheduled bath, as they did not have enough time. Review of Point of Care documentation and "LTC 24 hour report" identified that resident #002's bath was not made up prior to their scheduled bath. Confirmed with ADOC that PSW staff worked short two out of three days during the observation period. The resident was not provided the minimum bathing requirements.

C. The POC documentation and "LTC 24 hour report" identified that resident #099 did not receive a scheduled bath in February 2016, and there was no documentation to support that a make up bath was completed, nor did the documentation support that the resident refused, as confirmed by registered staff #107. The resident was not provided the minimum bathing requirements. [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 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, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A. In October 2015, resident #060 had multiple falls with injury. Review of the clinical health record indicated that a post fall assessment was not completed for two falls. Interview with DOC #001 and registered staff #103 confirmed that a post fall assessment was not completed by the registered staff after the resident fell.

2. The licensee failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available at the home.

Resident #060 fell in October 2015 and sustained an injury, resulting in registered staff #107 initiating a bed alarm and noted it was to be placed on the resident when in bed. A progress note in November 2015, stated the bed alarm was missing parts and initiated fifteen minutes checks for safety as the resident was high risk for falls. Later that evening, the resident sustained another fall. Interview with registered staff #107 stated the resident was to have a working bed alarm in place; however, the home did not have an extra bed alarm to replace the alarm that was missing parts, and confirmed that the home did not keep any extra bed alarms for the falls prevention program. (581) [s. 49. (3)]

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 when a when a resident has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

A. In October 2015 an altercation had occurred between resident #080 and resident #095. Review of the plans of care for both residents, identified that they were both cognitively impaired. The plan of care for resident #080 revealed that the resident had a history of responsive behaviours that increased in the evenings. The progress notes for resident #080 also revealed that the resident displayed behaviours that morning, that required staff interventions. Review of the "PSW Schedule" identified that on the evening of the unidentified day in October 2015, the home was working short two PSWs. Interview with registered staff #108 and PSW #124 confirmed that the resident displayed responsive behaviours that morning and had a history of altercation with resident #095. Interview with PSW#132 confirmed that they were working short that day and PSW staff were unable to prevent the altercation as they were providing care and did not witness it. Review of the "PSW Schedule" identified that on the evening in October 2015, the home was working short two PSWs.

Noting resident #080's responsive behaviours on the morning of the above incident and the staffing shortage of two PSW's that same evening, the staff were unable to implement interventions to prevent the altercation. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

**s. 73. (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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

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

Findings/Faits saillants :

1. The licensee failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the resident.

i) On February 2, 2016, a supper meal tray was provided to resident #006 in their room. Quiche was probed and recorded at a temperature of 53 degrees Celcius and asparagus measured 56 degrees Celcius.
ii) On February 3, 2016, a lunch tray was provided to resident #100 in their room. Soup measured at 53 degrees Celcius, potato 44 degrees Celcius and meat serving 41 degrees Celcius.

The home's policy, "Meal Service Temperature Standard –FSO-D-20", revised December 2015, stated all menu items were to be served in the acceptable standard temperature range, which the policy indicated and FSM confirmed as 60 degrees Celcius, to maintain quality of food. (585) [s. 73. (1) 6.]

2. The licensee failed to ensure that meals were served course by course for each resident.

A) On February 2, 2016, during an observation of lunch, residents at one table were served dessert before they completed their main course. PSW #113 reported the resident's main courses were to be completed and dishes removed before serving dessert.

B) On February 2, 2016, during an observation of supper in the large dining room, residents at two tables were served dessert before completing their main course. The director of nutrition services reported that meals were to be served course by course and confirmed it did not occur. (585) [s. 73. (1) 8.]

3. The licensee failed to ensure proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

A. On February 2, 2016, during supper, resident #040 was observed in a reclined position, and received assistance with eating from PSW #118. During the meal, PSWs repositioned the resident as they had visibly slid down in their chair. At a later point during the meal, the resident appeared in a reclined position and slouched again, while staff continued to feed the resident.

B. On February 2, 2016, during supper, resident #041 was heard coughing and observed slouched in their tilt wheelchair with their head and torso in a reclined position, receiving total assistance from PSW #109. The resident's plan of care indicated they were to be positioned in an upright position for safe eating. When approached by the inspector, the PSW confirmed the resident was not seated in an upright position and required repositioning.

DOC #002 confirmed in an interview that resident #040 and #041 should have maintained upright positions for safe eating. (585) [s. 73. (1) 10.]

4. The licensee failed to ensure that no person simultaneously assisted more than two

residents who needed total assistance with eating or drinking.

i) On January 27, 2016, during lunch, PSW #102 was observed and confirmed that they solely provided simultaneous total assistance with eating to resident #005, #041 and #090 as well as encouragement to resident #095 for 20 minutes.

ii) On January 27, 2016, during lunch, a PSW was observed to provide simultaneous assistance with eating through the course of the meal to resident #092, who required extensive assistance and resident #093 and #096 who required total assistance.

iii) On February 2, 2016, during supper, PSW #110 was observed to provide simultaneous assistance with eating to resident #092 who required extensive assistance and resident #093 and #096 who required total assistance. PSW #110 reported the home's expectation was to simultaneously assist no more than two residents who required total assistance; however, they did not want one resident to wait because there were no other staff available to help with feeding. (585) [s. 73. (2) (a)]

5. The licensee failed to ensure that a resident who required assistance with eating or drinking was not served a meal until someone was available to provide the assistance required by the resident.

Resident #004 required total assistance with eating, as confirmed by registered staff #112.

i) On February 2, 2016, during lunch in the main dining room, the resident was observed seated with their beverage in front of them, with no staff present to assist for ten minutes.

ii) On February 2, 2016, during supper in the main dining room, the resident was observed with two beverages in front of them and no staff present to assist for 30 minutes. While alone, the resident was heard asking for help. PSW #119 was observed beginning to assist the resident 15 minutes after they requested help and confirmed no staff was present to assist for 30 minutes. (585) [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure proper techniques are used to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

Residents #004, #006 and #007 triggered for inspection as clinical documentation indicated they experienced significant changes in weight. Interviews with PSW #127 and #128 revealed that since approximately October 2015, the Alenti tub scales used to measure weights were inaccurate, despite using them in accordance of instruction by the scale service technician. The RD also reported they had questioned the accuracy of the scales, as evidenced by requesting re-weighs of residents. DOC #001 confirmed the home had ongoing issues with the accuracy of the scales, despite attempts to have them serviced and confirmed they were not reliable. [s. 90. (2) (b)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were cleaned, in good state of repair, inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

Throughout the course of the inspection, the exhaust grills in both shower rooms were noted to be heavily covered with gray dust debris.
Interview with the ESM on February 8, 2016, identified that the homes preventative maintenance schedule included inspection and cleaning of the ventilation system; however, the exhaust grills were unclean and the heating, ventilation and air conditioning system had not been inspected or cleaned within the last six months. [s. 90. (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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #12: 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 failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On February 9, 2016, a medication cart was noted to be unlocked and in the hallway. One resident was standing beside the cart and two additional residents were self propelling themselves past the cart. The RN #123 was then observed exiting a resident's room and approached the cart, to dispense medications. Again, the RN #123 left the medication cart unlocked and left the cart in front of a resident's room and entered a different room to administer medications. The LTC Homes Inspector was able to open and close medication cart drawers without the RN being aware. Within two minutes RN #123 returned to the cart. Interview with RN #123 confirmed that the cart was left unlocked when unattended and reported they were close by. However, when shared the LTC Homes Inspector had access to the medications in the cart without staff being aware, they confirmed the cart should have been locked when unattended. [s. 129. (1) (a) (ii)]

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 #13: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in accordance with subsection 76(7) of the Act on falls prevention and management.

Education records provided by the home indicated that twenty five out of thirty four staff, (seventy- four percent) who provided direct care to the residents in 2015, did not receive annual training related to falls prevention and management and this was confirmed by the Executive Director. [s. 221. (1) 1.]

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, annual training in accordance with subsection 76(7) of the Act on the application and use and potential dangers of the PASDs.

Education records provided by the home indicated that twenty five out of thirty four staff, (seventy three per cent) who provided direct care to the residents in 2015 did not receive annual training related to minimizing the restraining of residents and this was confirmed by the Executive Director. [s. 221. (1) 6.]

3. Education records provided by the home indicated that twenty five out of thirty four staff, (seventy three per cent) who provided direct care to the residents in 2015 did not receive annual training related to responsive behaviours of residents and this was confirmed by the Executive Director. [s. 221. (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 staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, annual training in accordance with subsection 76(7) of the Act on falls prevention and management, PASDs, responsive behaviours, and skin and wound, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A. The home policy "Routine Practices IPC-B-10, revised December 2014" directed staff to complete hand hygiene before and after activities that may result in cross contamination, and specifically referred to "Four Moments of Hand Hygiene", which included but was not limited to before and after resident and resident environment contact.

During the course of the inspection, staff were observed for completion of hand hygiene and the following was identified:

i. On February 2, 2016, at approximately 0800 hours, PSW #120 exited a resident room with a garbage bag containing a soiled brief. The garbage bag was disgarded and then the staff entered the tub room. Less than five minutes later, the staff member exited the tub room and entered a third room. No hand hygiene was observed.

ii. On February 3, 2016, at approximately 1130 hours, PSW #100 walked out of one resident room carrying a soiled brief contained in a garbage and entered another resident's with the bag. At the same time, PSW #121 exited a resident room with dirty linen disgarded the linen, and walked into help PSW #100. No hand hygiene was observed completed by either PSW.

Approximately 20 minutes later, PSW #100 brought in a brief to a resident's room to assist the resident in the bathroom. A few minutes later the PSW went to the linen cart for clean towel and gown, which were brought into a second resident's room, no hand hygiene observed.

iii. On February 5, 2016, at approximately 0900 hours, PSW #121 was observed exiting a resident's room with soiled linens, which were discarded, and then walked into another resident's room. No hand hygiene was observed.

Interview with PSW staff confirmed that hand hygiene was to be completed before and after contact with the residents and their environment, including morning care. (528) [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control system, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that there was least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation)

Note: In this section "regular nursing staff" means a member of the registered nursing staff who works in a long-term care home at fixed or prearranged intervals

Review of the homes registered staff schedule identified that on December 28, 2015, from 1500 to 2200 hours, the home did not have one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times. RPN #126, who was an agency staff member was the only registered staff in the home. On February 8, 2016, in an interview with the ED, it was identified that due to unavailability of regular nursing staff and agency registered nurses, the ED was in the home with RPN #126, with the DOC available by phone. Furthermore, it was RPN #126's first shift in the home.

On December 28, 2015, the licensee did not meet the criteria for allowable exemptions as in section 45 (1) and 45.1 of the regulations, which would require the RPN to be a member of the regular nursing staff. [s. 8. (3)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to shall ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

In January 2016, resident #100 was observed laying on their air mattress and and strong odour was detected from the mattress. The odour remained present the following week. Interview with PSW staff #104 and #120 confirmed that the resident was incontintent of bladder and bowel and due to cognitive impairment often refused to get out of bed; therefore, cleaning the mattress was a challenge. However, both PSW's indicated that housekeeping wiped the air mattress down on the resident's shower days.

Review of the manufacturer's instructions Therapeutic Surface Solutions Inc. Low Air Loss Therapeutic Surface Cleaning instructions, which directed the following:
i. for lighter soils, the therapy pad can be cleaned topically and wiped down with soap and water solution. If grossly soiled the therapy pad is to be replaced with a clean therapy pad. Laundry staff were to separate the pad from the base of enclosure, unzip bolstered cover along outer edge, remove foam bolsters from cover and ensure cover was zipped close before laundering.

PSW #104 and housekeeping staff #131, could not recall when the mattress was deeply cleaned. Interview with DOC #002 identified that the home did not have a record of when resident #099's mattress covers was laundered. (528) [s. 23.]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure the use of a Personal Assistance Services Device (PASD) under subsection (3) to assist a resident with a routine activity of living was included in a resident's plan of care only if all of the following were satisfied:
1. Alternatives to the use of a PASD had been considered and tried where appropriate.
3. The use of the PASD had been approved by, a physician, a registered nurse, a registered practical nurse, a member of the College of Occupational Therapist of Ontario, a member of the College of Physiotherapist of Ontario, or any other person provided for in the regulations.
4. The use of the PASD had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Resident #005 was observed sitting in their tilt wheelchair which was in the tilted position on multiple days during the course of this inspection. Registered staff #107 and PSW staff #102 stated they were in their tilt wheelchair for positioning and comfort and to assist them with activities of daily living. Review of the clinical record indicated there was no documented assessment for the use of the tilt wheelchair as a PASD, nor any documented consent or approvals for its use. Registered staff #107 confirmed that the tilt wheelchair was not assessed as a PASD, nor did they have documented consent or approval for its use. (581) [s. 33. (4)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee failed to ensure that mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who require them on a short-term basis.

Review of the written plan of care for resident #005 identified they were walked with a walker or two person assistance with a gait belt. Interview with the Physiotherapist (PT) indicated that the resident was only walked with two person assistance with a gait belt, as there was no walker available in the home to use for walking them. Interview with registered staff #107 confirmed that the home did not have any spare walkers in the home at this time for residents who required them on a short-term basis. (581) [s. 39.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds had been assessed by a registered dietitian who was a member of the staff of the home, and had any changes made to the plan of care related to nutrition and hydration implemented.

A. In December 2015, the plan of care for resident #002 identified that the resident had a new area of skin breakdown related to pressure. The area was immediately assessed and treated and healed within two weeks; however, the RD was not notified. In January 2015, the same area of skin was noted to be altered and a referral was sent to the RD. Review of the plan of care included a Quarterly Assessment from the RD on January 21, 2016, which identified that the resident was a moderate nutritional risk with no alterations in skin. Interview with the RD confirmed that a referral was not submitted related to skin until the end of January 2016. During the course of the inspection, the resident had not been assessed related to the skin and wound by the RD (528) [s. 50. (2) (b) (iii)]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that they responded in writing with ten days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Resident Council Meeting Minutes from March 31, 2015 to November 24, 2015, identified that not all concerns or recommendations received were responded to in writing within ten days.

Meeting minutes from November, 2015, included a recommendation that residents would receive a cupcake on their birthday and they would like a watering can to help water the plants in the home. Interview with the Executive Director confirmed that both recommendations were not responded to in writing to the Resident Council. (581) [s. 57. (2)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that planned menu items were offered and available at each meal and snack.

On February 2, 2016, two per cent milk was on the planned menu for lunch. During an observation of lunch in the small dining room, milk was not offered to residents. Interview with dietary staff #114 reported milk was only offered to residents who had it specifically noted on their diet profile. The FSM confirmed two per cent milk was on the planned menu and should have been offered to all residents. (585) [s. 71. (4)]

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

Review of the family council minutes from March 2015 until November 2015 identified that the family council did not have input in developing and carrying out the satisfaction survey and this was confirmed by the Executive Director. (581) [s. 85. (3)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records

Specifically failed to comply with the following:

s. 233. (1) Every licensee of a long-term care home shall ensure that the record of every former resident of the home is retained by the licensee for at least 10 years after the resident is discharged from the home. O. Reg. 79/10, s. 233 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the record of every former resident of the home was retained by the licensee for at least 10 years after the resident was discharged from the home.

In October 2015, resident #060 fell and was sent to hospital for assessment and treatment. The resident was discharged from the home the following month. On February 4, 2015, inspector requested the resident's clinical health records and DOC #001 confirmed that the home was unable to locate their discharged record and the home did not retain resident #060's record after being discharged. (581) [s. 233. (1)]

Issued on this 17th day of March, 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 sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CYNTHIA DITOMASSO (528), DIANNE BARSEVICH (581), LEAH CURLE (585)
Inspection No. / No de l'inspection :	2016_267528_0003
Log No. / Registre no:	002232-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 8, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	TELFER PLACE 245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Catherine Donahue

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_188168_0007, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents including residents #004 and #006 are provided with nutritional care as outlined in their plans of care related to receiving nutritional supplements, dietary interventions and fluid consistencies, safe positioning and monitoring after meals as well as recording and monitoring of weights according to their plans of care.

This plan to be submitted to leah.curle@ontario.ca by April 19, 2016

Grounds / Motifs :

1. A. Previously issued as a CO in March 2016, a VPC in April 2014. The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'pattern'.

B. Resident #004's plan of care stated they were at high nutritional risk and interventions in their plan included but were not limited to providing nutritional supplements at meals, thickened fluids, remain upright after eating and record weights twice a month.

Review of the resident's medication administration record (MAR) and observations during meals and snacks revealed the resident did not receive their nutritional supplements as indicated in their plan of care:

i. In November 2015, December 2015 and January 2016, the MAR indicated they did not always receive nutritional supplements as they were unavailable. On February 2, 2016, during a supper observation, they did not receive their

nutritional interventions as the home was unable to thicken it to the appropriate consistency, as confirmed by registered staff #112.

ii. On February 4, 2016, during a morning nourishment observation, the resident did not receive their nutritional intervention as confirmed PSW #121 and registered staff #105.

iv. On February 2, 2016, during a lunch observation, the resident received nutritional intervention that was not thickened as per the resident's plan of care. The FSM confirmed the beverage was not the appropriate thickness. Following confirmation of the inappropriate fluid consistency, registered staff #108 was observed and confirmed they added an additional scoop of thickener to the partially consumed beverage and provided it back to the resident, not following direction as indicated on the thickener container.

v. On February 2, 2016, after lunch and supper, the resident was observed tilted back and unsupervised 10 minutes after eating. Registered staff #108 stated the resident was to remain monitored and upright 30 minutes post meals.

vi. In November and December 2015, the resident was not weighed twice a month, as confirmed by the RD.

C. Resident #006's plan of care stated they were at high nutritional risk. Their plan of care stated they were to provide interventions with foods including and thickened fluids and specific nutritional intervention at breakfast.

i. On February 2, 2016, during a supper observation, the resident was provided a meal that did not include additional interventions as confirmed by dietary staff #116. Interview with the RD confirmed the resident was to receive the additional interventions.

ii. On February 2, 2016, during supper, the resident received a beverage that appeared to be a consistency, thinner than required in the plan of care, as confirmed by PSW #110.

iii. Review of the resident's medication administration record (MAR) from December 2015 to February 2016, revealed they did not always receive their nutritional supplement at breakfast, as it was unavailable. Registered staff #112 confirmed at times, the supplement was not available in the home and therefore

not provided to the resident. (585) (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 69. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Order / Ordre :

The licensee shall ensure that following:

a. Resident #004, #006 and #007's weight changes are assessed by the end of every month, as outlined in the home's policy, using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.
b. Staff are using a scale that is in good working order to ensure accuracy of weights.

Grounds / Motifs :

1. A. Previously issued as a CO in June 2013. The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'widespread'.

B. Resident #004's plan of care indicated they were at high nutritional risk, as confirmed by the RD.

In November 2015, the resident had a weight change of 23.7 per cent over six months and 26.1 per cent over two months, as indicated in their weight records. Review of their clinical record revealed the RD completed an assessment in November 2015, and implemented interventions to promote caloric, fluid and

fibre intake and to weigh the resident twice a month.

In December 2015, the resident was identified to have a weight change of 9.4 per cent over one month and 19.2 per cent over three months. In January 2016, they were identified to have a weight change of 9.9 per cent over two months and 18.8 per cent over six months. No information was noted regarding a three month change as no weight was recorded in October 2015. In February 2016, the resident triggered for a weight change of 20.5 per cent over one month. In a review of the resident's clinical record, no interdisciplinary assessments were conducted regarding the continued triggered weight changes in December 2015, January 2016 and February 2016, weights were not measured and recorded twice a month, and no evaluation of the actions taken in November 2015 occurred, which was confirmed by the RD.

C. Resident #006's plan of care indicated they were high nutritional risk.

In October 2015, the resident was identified was having a weight change of 7.3 per cent over one month and 10.2 per cent over two months, as indicated in their weight records. Review of their clinical record revealed the RD completed assessments in October 2015, and implemented interventions to promote food and fluid intake.

In November 2015, the resident has weight change of 10.2 per cent over three months and 11.2 per cent over six months. In December 2015, the resident had a change of 8.4 per cent over three months. In a review of the resident's clinical record, no interdisciplinary assessments were conducted regarding the continued triggered weight changes in November and December 2015, which was confirmed by the RD.

D. In October 2015, resident #007 experienced a weight change of 5.2 per cent over one month, 11.5 per cent over three months, and 10 per cent over six months, as indicated in their weight records. Review of their clinical record revealed the RD completed an assessment of the resident in October 2015 and implemented nutrition interventions to promote caloric intake and prevent weight loss.

In November 2015, the resident's weight record noted they experienced a weight change of 10.7 per cent over three months and 11.4 per cent over six months. In December 2015, records noted a weight loss of 12.1 per cent over six

months. In a review of the resident's clinical record, no interdisciplinary assessment was conducted regarding the continued triggered weight changes over three and six months, as identified in November and December 2015, nor was there a noted evaluation of the actions taken in October 2015, which was confirmed by the RD.

E. The home's policy, "Height Measurement and Weight Management – Index: TC-G-60" revised June 2014, stated the weight record will be reviewed monthly, a nutrition referral to the RD will be completed and information documented in the interdisciplinary progress notes for weight variances in residents as outlined under O. Regulation 69. The RD confirmed they did not receive referrals for the changes identified for resident #004, #006 and #007, nor were interdisciplinary progress notes made regarding the variances. (585) (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_188168_0007, CO #002;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that food and fluids served to residents are prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality.

This plan is to be submitted to Leah.Curle@ontario.ca by April 17, 2016.

Grounds / Motifs :

1. 1. Previously issued as a compliance order (CO) in March 2015
2. Previously issued as a voluntary plan of correction (VPC) in June 2013.
The non-compliance issued was determined to have a severity of 'potential for actual harm/risk' with a scope of 'isolated'.

3. As directed in the CO issued in March 2015, the home failed to develop or revise current recipes for all pureed menu items to clearly direct staff on the desired consistency of each item included on the menu. In February 2016, recipes used to direct staff on the preparation of puree items were reviewed and did not all contain clear direction for staff on the desired consistency of each item included on the menu, which was confirmed by the FSM.
4. As directed in the CO issued in March 2015, the home failed to implement a process for reporting of concerns related to food consistency and documentation of actions taken to address the concerns. On February 3, 2016, during breakfast, pureed egg and toast were observed and confirmed by dietary staff #133 to be an inappropriate consistency. On February 8, 2016, the food service

manager (FSM) reported the home's process for reporting concerns was verbal and they had not received information regarding concerns of the consistency of pureed items.
5. In January 2016, a complaint was submitted to the Ministry of Health and Long-Term Care regarding concerns related to the quality of food served to residents at breakfast, as it was reported that residents were not receiving their meals until after 1000 hours.
6. On February 4, 2016, pureed eggs and bread were observed in the kitchen in the steam table at 0930 hours. Interview with dietary staff #133 reported the pureed eggs and toast were prepared at 0815 hours. Pureed egg was sampled and noted containing clumps and required chewing to swallow. Pureed toast was sampled and sticky, requiring chewing to swallow. Oatmeal appeared overcooked and gummy. Dietary staff #133 confirmed the textures were not acceptable, and after 0930 hours, breakfast items were typically thrown out.
7. At 0955 hours, a prepared tray for resident #101 was observed sitting on a cart in dining room that contained pureed egg, toast and oatmeal, milk and juice. Interview with dietary staff #115 reported the tray was prepared between 0920 and 0930 hours, as it was to be delivered to the resident at that time. At 1015 hours, the tray was still in the dining room, with no staff available to provide it as reported by PSW #100.
8. On January 27, 2016, during lunch, broccoli served appeared green/brown and crumbly.
9. On February 2, 2016 during supper, asparagus served appeared overcooked and stringy. (585)
(585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 17, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Order / Ordre :

The licensee shall ensure that the Executive Director does not administer a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

Grounds / Motifs :

1. The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. This noncompliance was issued with a severity of risk of harm with a scope of pattern.

On December 28, 2015, during evening medication pass, RPN #126 dispensed medications from the medication cart according to the electronic medication administration record (eMARS), and then gave them to the ED to administer to the residents. Interview with staff #128 confirmed that the ED had administered medications to more than one resident on the identified day. Review of the home's 2015 Staffing Plan Evaluation, which documented that the ED carried medications to residents after they had been dispensed by RPN #126, including one insulin. Interview with the ED on February 8, 2016, confirmed that on December 28, 2015, RPN #126 dispensed medications and then the ED carried the medications to the resident and administered the medications, including one subcutaneous insulin. The ED confirmed that they were not registered under the College of Nurses. (528)

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 : Mar 09, 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 sions 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 sions 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 8th day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cynthia DiTomasso

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