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 soins de longue durée**

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 3, 2017 | 2017_555506_0007 | 030923-16, 003441-17 | Complaint |

### 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

LESLEY EDWARDS (506), LISA VINK (168)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): February 13, 14, 15, 17 and 21, 2017**

**This complaint inspection was completed concurrently with inspection numbers 2016_188168-0020/log #029573-16 and 2017_556168-005/log #31617-16. Non compliance for s. 101. (2) and s. 135. (1)(b) will be identified on inspection report 2016_188168-0020/log #029573-16.**

**This complaint inspection was conducted related to plan of care, infection prevention and control program, administration of medications, medication regimes and duty to protect.**

**During the course of the inspection, the inspector(s) spoke with The Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Former Executive Director, Former Director of Cares, Environmental Service Supervisor (ESS), housekeeping staff, registered nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Oxygen Vendor, Hospice Outreach Nurse, residents and families.**

**During the course of the inspection the inspector toured the home, observed care and services, reviewed clinical health records, reviewed policies and procedures, conducted interviews and reviewed the home's complaints process.**

**The following Inspection Protocols were used during this inspection:**
**Infection Prevention and Control**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The home had a procedure "Medication Administration, CARE 13-010.01, effective date August 31, 2016" as part of the written policies and protocols developed for the medication management system required under Regulation 114 (2), which identified:
i. That all "medications administered, refused, or omitted will be documented immediately after administration on the MAR/TAR or eMAR/eTAR using the proper codes by the administering nurses".
ii.That medications must be observed for ingestion, otherwise, it cannot be considered administered.

A) RPN #103 worked at the home on an identified date in October 2016. Interview with the RPN identified that they were on shift on the unit at this time and did not have an individualized or a confidential user name and password or access to the home's electronic documentation system and electronic Medication Administration Records (eMARs). The RPN indicated that during the shift they documented on the eMARs, for residents which they administered medications to, using the user name and password given to them by RN #109, which was the RN's user name and password.
A review of the eMARs for resident #011, #002 and #003 included the initials of the RN on an identified date in October 2016, as the person who administered medications on the specified date. Interview with RN #109 verified that there had been occasions when they did give out their user name and passwords to new staff and agency staff during this time period and confirmed that with the comfort level of the RPN they would have had the RPN shadow them during the supper medication pass and would have supervised the evening medication pass.
The procedure "Medication Administration" was not complied with when the staff who administered the medication did not sign that they administered the medications as required.

B) Resident #011 on an identified date in October 2016, was given their scheduled medications at 2000 hours. RPN #103 left the resident's medications at the bedside. When RN #113 went to the resident's room at 2240 as the resident requested analgesic medication they noted the resident's medications from 2000 were still at the bed side and the resident was upset that the medications were left there and refused to take the medications that were left at the bedside. The resident at this time needed to take breakthrough medication. The procedure for "Medication Administration" was not complied with when the staff who administered medications did not observe the medications being ingested by the resident and therefore the resident did not receive their scheduled medications on time and required breakthrough medication. [s. 8. (1) (b)]

2. The home had a procedure "Oxygen Therapy, LTC-F-120, effective date November 2015" as part of the written policies and protocols developed for the medication management system required under Regulation 114 (2), which identified that the home will have a process in place to ensure appropriate supplies and equipment are available, cleaned and maintained.

A) On identified dates in February 2017, two residents were found to have empty oxygen devices. The home had identified that the devices were to be filled daily at 0600 hours by the night shift, this was assigned to the PSW's job routine and checked throughout the shift by the day and evening shift. PSW #114 confirmed that the devices last only two to three hours if running continuously. A review of the PSWs day and evening shift job routine did not identify how often or when to check the devices nor was there anywhere to sign that this task had been completed. The home identified care and monitoring required for oxygen devices on point of care POC, for one of the residents. The monitoring and care of the device was not included in the POC for the second resident. The ADOC confirmed that the home did not follow their policy. [s. 8. (1) (b)]

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

The home had a procedure in place for Housekeeping Services identified as 5.1.7- Wet Mopping Hard Floor surfaces- Micro fibre / Spool Mop Head, issued January 2015. This document was given to the Inspector and identified by the ED and ESS to be the current procedure in place for cleaning floors in the long-term care home. The procedure identified that for safety "if mopping large areas which have resident presence, mop only half the room at a time, allow to dry and then complete the other side".

O Reg 79/10, section 87 requires long-term care homes, to as part of the organized program of housekeeping under clause 15(1)(a) of the Act, to ensure that procedures are developed and implemented for, cleaning the home including common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces.

Resident #090, who had a history of falls was found on the floor by a co-resident. Investigation of the incident identified that at the time of the fall the floor in the area was wet and no signage had been posted to alert residents or staff of the potential hazard. Interview with the ESS verified that they were informed of the wet floor and lack of floor sign at the time of the fall. Housekeeping staff #207 was interviewed and verified that they had seen the resident in the area, that they mopped the floor and placed a wet floor sign in the area prior to leaving on the identified day. The housekeeping staff verified that the entire floor was mopped at the same time, not only half of the floor, allow time to dry and then complete the remainder of the floor.
The procedure for mopping the floors was not followed as required.

This finding of non-compliance was identified during CIS Inspection 031617-16, for Critical Incident 2742-000015-16. [s. 8. (1) (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 staff are following the home's policies and procedures for medication and treatment administration and housekeeping services, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that the care set out in the plan of care was provided to two residents as specified in their plan.

A) Resident #011's plan of care directed staff that the resident was to receive a specified treatment. On an identified date in February 2017, the resident was feeling unwell and it was noted that the treatment was not provided as ordered. The resident's order identified that the resident required the treatment. RN #101 confirmed that the home did not follow the resident's plan of care.
B) Resident #052's plan of care directed staff that the resident was to receive a specified treatment. On an identified date in February 2017, the residents treatment was not provided as ordered. The ADOC confirmed that the staff did follow the resident's plan of care. [s. 6. (7)]

***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 care set out in the plan of care is provided to residents as specified in their plan, to be implemented voluntarily.***

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**Issued on this 24th day of May, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | LESLEY EDWARDS (506), LISA VINK (168) |
| **Inspection No. / No de l'inspection :** | 2017_555506_0007 |
| **Log No. / Registre no:** | 030923-16, 003441-17 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Mar 3, 2017 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>55 STANDISH COURT,8TH FLOOR, MISSISSAUGA, ON, L5R-4B2 |
| **LTC Home / Foyer de SLD :** | TELFER PLACE<br>245 GRAND RIVER STREET NORTH, PARIS, ON, N3L-3V8 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Ruthanne Foltz |

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

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall ensure that the home's policy and procedure for Medication Administration will be followed:

1. To ensure that all employees and agency staff that are working at the home have an individualized or confidential user name and password to access the home's electronic documentation system and electronic Medication Administration Records as per the home's policy.

2. To ensure that all employees and agency staff do not share their individualized or confidential user name and password to access the home's electronic documentation system and electronic Medication Administration Records.

3. To ensure that all residents who must be observed for medication administration are observed for ingestion before documenting that the medication has been administered.

**Grounds / Motifs :**

1. Judgement Matrix:
Severity- Actual Harm/Risk
Scope- Widespread
Compliance History- Previously issued as a VPC on June 2016 and January 2016

The home had a procedure "Medication Administration, CARE 13-010.01, effective date August 31, 2016" as part of the written policies and protocols developed for the medication management system required under Regulation 114 (2), which identified:
i. That all "medications administered, refused, or omitted will be documented immediately after administration on the MAR/TAR or eMAR/eTAR using the proper codes by the administering nurses".
ii.That medications must be observed for ingestion, otherwise, it cannot be considered administered.

A) RPN #103 worked at the home on an identified date in October 2016. Interview with the RPN identified that they were on shift on the unit at this time and did not have an individualized or a confidential user name and password or access to the home's electronic documentation system and electronic Medication Administration Records (eMARs). The RPN indicated that during the shift they documented on the eMARs, for residents which they administered medications to, using the user name and password given to them by RN #109, which was the RN's user name and password.
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The procedure "Medication Administration" was not complied with when the staff who administered the medication did not sign that they administered the medications as required.
B) Resident #011 on an identified date in October 2016, was given their scheduled medications at 2000 hours. RPN #103 left the resident's medications at the bedside. When RN #113 went to the resident's room at 2240 as the resident requested analgesic medication they noted the resident's medications from 2000 were still at the bed side and the resident was upset that the medications were left there and refused to take the medications that were left at the bedside. The resident at this time needed to take breakthrough medication.
The procedure for "Medication Administration" was not complied with when the

staff who administered medications did not observe the medications being ingested by the resident and therefore the resident did not receive their scheduled medications on time and required breakthrough medication. (506)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 14, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

**Issued on this 3rd day of March, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

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