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 # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 3, 2017 | 2017_573581_0009 | 011833-17 | Resident Quality Inspection |

### Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

### 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

DIANNE BARSEVICH (581), JESSICA PALADINO (586), LESLEY EDWARDS (506), LISA BOS (683)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 22, 23, 26, 27, 28, 29, 30, July 4, 5, 6 and 7, 2017.**

**During the course of the inspection the following inspections were completed concurrently:**
**Complaints:**
**Log number, 006532-17 for info line number IL-50029-HA related to personal care.**

**Critical Incidents:**
**Log number 008726-17 related to reporting of alleged abuse.**

**Inquiries:**
**Log number, 027376-16 related to falls prevention.**
**Log number, 004404-17 related to falls prevention and pain management.**
**Log number, 003990-17 related to resident to resident abuse.**
**Log number, 001674-17 related to falls prevention.**
**Log number, 007241-17 related to alleged verbal abuse.**
**Log number, 030443-16 related to staffing shortage.**

**During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Associate Director of Care (ADOC)/ Resident Assessment Instrument (RAI) Coordinator, Physiotherapist Assistant (PTA), Registered Dietitian (RD), Personal Support Workers (PSW), residents and families.**

**During the course of this inspection, the inspectors: observed the provision of services, toured the home, reviewed records including but not limited to: meeting minutes, training records, policies and procedures and clinical health records.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

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

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

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 8. (1) | CO #001 | 2017_555506_0007 | 506 |

| 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 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 at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was 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.)

Review of the registered nursing staffing schedule from April 1 to July 6, 2017, identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty on the following dates:
i. On April 5 and 9, 2017, on evening shift.
ii. On April 21, 22, 24 and 25, 2017, on night shift.
iii. On April 15, 16, 2017, on day shift.
iv. On May 16, 17, 20, 21, 27 and 29, 2017, on evening shifts.
v. On June 1, 16, 19, 22 and 24, 2017, on evening shift.
vi. On June 23, 2017, on night shift.
vii. On July 1 and 2, 2017, on evening shift.

Interview with the DOC stated there was no RN in the building on April 9 and 15, 2017 on day shift and on May 16, 27, 29, June 16, 19 and 24, 2017, on evening shift and that agency RN staff was present on the other shifts listed above. The DOC confirmed that the home was unable to staff those shifts with an RN who was an employee of the home. [s. 8. (3)]

***Additional Required Actions:***

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

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**WN #2: 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).**

**Findings/Faits saillants :**

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

Review of the home's, " Fall Prevention and Injury Reduction Program, in the CARE Manual, index number: CARE 010.02, effective date August 2016", identified that for all falls, a clinical assessment would be completed and documented, including vital signs every shift for a minimum of 72 hours.

Resident #008 sustained three unwitnessed falls on three identified days in April, May and June 2017. Review of the plan of care identified that the post fall note was not completed on the following shifts:
i. Three evening shifts in June.
ii. Two identified night shift in May 2017.
iii. An identified night and evening shift in April 2017.

B. Resident #007 sustained an unwitnessed fall on an identified day in June 2017, which resulted in an injury. Review of the plan of care identified that the post-fall note was not completed on the following dates:
i. An identified evening shift in June 2017.
ii. Another identified night and evening shift in June 2017.

Interview with RN #104 stated that a clinical assessment was to be completed post falls for a minimum of 72 hours and confirmed the post fall assessment and documentation were not completed on the above dates. Interview with the DOC stated that post falls notes were part of the clinically appropriate assessment. (586) [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances for the resident requires, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

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

**s. 52. (1) The pain management program must, at a minimum, provide for the following:**
**1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).**
**2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).**
**3. Comfort care measures. O. Reg. 79/10, s. 52 (1).**
**4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that as part of the pain management program, residents' responses to, and the effectiveness of the pain management strategies was monitored.

Review of the home's, "Pain Assessment and Symptom Management Program, in the Care Manual, index number: CARE 8-P10, last reviewed July 31, 2016" and the procedures titled "Pain Assessment and Management index number: CARE 8-O10.02, last reviewed July 21, 2016", identified the effectiveness of pain interventions were to be monitored, resident outcomes were to be evaluated and would be documented.

The 72-Hour Pain Monitoring Tool for resident #031 was reviewed from five identified days in March and April 2017. The document included a chart for which staff were to identify the resident's pain prior to the intervention, what the intervention was and post intervention monitoring, which specified 30 minutes to one hour post intervention. The resident received medication as needed for pain on four specific days in March and five specific days in April 2017. Pain levels ranged on a scale out of 10. Of these, the post intervention monitoring was not completed on two identified days in March 2017 and on three identified days in April 2017. Interview with RN #100 on an identified day in July 2017, confirmed that it was the expectation of the home that registered staff completed the post intervention monitoring section of the 72-hour pain monitoring tool and that it should have been completed for the identified dates.
The licensee did not ensure that resident #031's response to, and the effectiveness of the pain management strategies were monitored. [s. 52. (1) 4.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the pain management program, residents' responses to, and the effectiveness of the pain management strategies is monitored, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

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

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (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, training in the areas set out in the regulations at the times or at intervals provided for in the regulations: Ont. Reg. 79/10 s. 221 (1) 2 identified that for the purposes of paragraph 6 of subsection 76 (7) of the Act, the following were other areas in which training would be provided to all staff who provided direct care to residents: skin and wound care; Ont. Reg. 79/10 s. 221 (2) identified that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act on an annual basis.

A review of the mandatory training records provided by the home for 2016, did not include that all staff received training in the area of skin and wound care. Interview with RPN #118 acknowledged that according to the records available for staff training in 2016, approximately 23 percent of direct care staff received training in the area of skin care and pressure ulcers. The Administrator confirmed that the home was unable to provide training records to confirm that all direct care staff received the required annual training. [s. 76. (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 receives, as a condition of continuing to have contact with residents, training in the areas set out in the regulations at the times or at intervals provided for in the regulations: Ont. Reg. 79/10 s. 221 (1) 2 identifies that 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: skin and wound care; Ont. Reg. 79/10 s.221 (2) identifies that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act on an annual basis, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

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

**s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:**
**1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).**

**s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:**
**4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the restraining of a resident by a physical device under section 31 or 36 of the Act, was applied by staff in accordance with any manufacturer's instructions.

On an identified day in June 2017, resident #001 was observed seated in a wheelchair with a physical device applied, which was not applied as per manufacturer's instructions. Review of the plan of care identified they required the physical device as a restraint. Interview with RPN #102 stated that the resident was unable to release the device independently and was assessed as a restraint. They confirmed that the device was not applied correctly, according to the manufacturer's instructions.
The restraint was not applied in accordance with manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee failed to ensure that where a resident was being restrained by a physical

device under section 31 of the Act, that the resident was released from the physical device and repositioned at least every two hours.

On an identified day in June 2017, resident #001 was observed sitting in their wheelchair with a physical device fastened for over four hours and was not released from the device or repositioned during that time. Review of the plan of care identified the resident required the device as a restraint to prevent injury and was to be checked hourly. The device was to be released every two hours and the resident repositioned. Interview with PSW #105 stated that they checked the resident hourly but did not release the device or reposition them. Interview with the DOC confirmed the resident should have been released from the device and repositioned every two hours. [s. 110. (2) 4.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and included every release of the device and all repositioning.

On two identified days in June 2017, resident #001 was observed in their wheelchair with a physical device applied. Review of the plan of care identified they required the device as a restraint. Review of Point of Care (POC) documentation revealed that under restraint utilization of the device, PSW staff were to document under three follow up questions which were as follows:
i. Restraint was on and resident was checked for safety.
ii. Resident repositioned at this time (minimum of every two hours).
iii. Restraint was off and resident checked for safety.

Interview and review of the home's POC documentation of restraints with the DOC confirmed that there were no follow up questions for the PSW staff to document the releasing of all physical devices. Review of the POC on an identified day in June 2017, revealed that PSW staff were documenting they repositioned the resident prior to when they were to reposition them. Interview with the DOC confirmed that PSW staff should of been documenting at the time the task occurred and not before and stated that POC would be updated to include the documentation of releasing of all physical devices used to restrain a resident. [s. 110. (7) 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 restraining of a resident by a physical device under section 31 or 36 of the Act, is applied by staff in accordance with any manufacturer's instructions and that where a resident is being restrained by a physical device under section 31 of the ACT, that the resident is released from the physical device and repositioned at least every two hours, to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and includes every release of the device and all repositioning, to be implemented voluntarily.***

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**WN #6: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**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 sets out the planned care for the resident.

Resident #002 was observed during the course of the inspection with a physical device applied. They were able to apply and remove the device independently. Interview with PSW #106 stated the resident liked to have the device on for safety and was always applied when up in their wheelchair. Review of the plan of care did not identify the resident had a device applied when up in the wheelchair. Interview with RPN #108 confirmed that the application of the device was planned care for the resident and was not documented in the plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the SDM was provided the opportunity to participate fully in the development and implementation of the plan of care.

Review of the progress notes for resident #031 identified that on an identified day in March 2017, RPN #121 was informed by a PSW that the resident had a specific oral care concern. RN #122 called the resident's substitute decision maker (SDM) two days later and acknowledged that the resident had an oral care issue. A progress note from the DOC on an identified day in March 2017, revealed that the SDM was concerned that they had been updated on the resident's condition several times during that time period but was not informed of the oral care concern. Interview with the DOC on an identified day in July 2017, identified that the home's expectation was that when a resident had a specific oral care concern, the registered staff were to notify the SDM at an appropriate time of day. They confirmed that RPN #121 should have notified resident #031's SDM of the oral care issue on an identified day in March 2017, when it happened, as the time the staff noticed the concern it was an appropriate time to make the phone call.
The licensee did not ensure that resident #031's SDM was informed of their specific oral care concern on an identified day in March 2017. [s. 6. (5)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months when, the resident's care needs changed or care set out in the plan was no longer necessary.

A. Resident #008 was observed during the course of this inspection not wearing eye glasses. Review of the plan of care indicated that they wore glasses at all times and required reminders. Interview with PSW #107 stated the resident refused to wear their

eye glasses for the past few months. Interview with RN #104 confirmed the resident no longer wore their eye glasses and confirmed the plan of care was not reviewed when the plan was no longer necessary.

B. Review of the plan of care for resident #008 identified they had a dental appliance and required oral care assistance. Interview with PSW #107 stated the resident refused to wear their dental appliance for the past couple of months. Interview with RN #104 stated the resident no longer wore their dental appliance and confirmed the plan of care was not reviewed and revised when the plan was no longer necessary.

C. Resident #031's SDM voiced concern to the LTC Inspector that on an identified day in March 2017, RN #123 advised them to send the resident to the hospital, even though they indicated that they did not want the resident sent to the hospital at any time and wanted them to remain in the home. On an identified day in June 2017, resident #031 was sent to the hospital as per the on-call physician's directive, as the home could not reach the resident's SDM. The resident's SDM stated that they had communicated these wishes to the home in the past. A return from hospital progress note written by RN #124 on an identified day in September 2014, identified that the resident's SDM was upset that the home had sent the resident to the hospital when they had specific directives and the RN informed the SDM that the plan of care had not been updated to those directives. Review of the resident's health record identified the SDM came to the home and signed the directives on an identified day in September 2014; however, there was no documentation stating the fact that the SDM did not want the resident sent to the hospital and this was not added to the plan of care. (586) [s. 6. (10) (b)]

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**WN #7: 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 where the Act or this Regulation required, any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, r. 48. (1) required every licensee of a long term care home to ensure that the following interdisciplinary programs were developed and implemented in the home: 2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers and provide effective skin and wound care interventions.

The home had a procedure, "Skin and Wound Care, in the Care Manual, index number: CARE 12-010.04, effective date August 31, 2016". which identified:
i. That all bruises, rashes and abrasions would be classified as alteration in skin integrity and a progress note would be written to indicate the size, location, colour and characteristics of the altered skin integrity.

On an identified day in July 2017, the Long Term Care (LTC) Inspector observed the resident with a specified intervention on a specific part of the resident's extremity and also noted another skin impairment. On an identified day in July 2017, in an interview with RN #104, who was the home's designated lead for the wound care program indicated they were not aware the resident had any areas of altered skin integrity. A review of the resident's clinical record did not indicate any documentation regarding the resident's area of altered skin integrity. An interview with RN #104 confirmed the home did not follow their skin and wound care policy regarding bruises, rashes and abrasions as there was no documentation in the progress notes classifying the wound or indicating the size, location, colour or characteristics of the altered skin integrity. [s. 8. (1) (b)]

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

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

**s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
**(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**
**(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**
**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**
**(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**
**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**
**(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**
**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**
**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with related to s. 20 (2) (d), the duty under section 24 to make mandatory reports.

Review of the home's, "Resident Non-Abuse Program, in the Administration manual, index number: ADMIN1-P10-ENT, last reviewed July 31, 2016", indicated that, "Anyone who becomes aware of, or suspects abuse or neglect of a Resident must immediately report that information to the Executive Director or, if unavailable, to the most senior supervisor on shift." Review of resident #030's clinical health record, the Critical Incident System (CIS) report and the home's internal investigation notes identified that resident #030 reported alleged abuse by two staff members to RN #120 on an identified day in April 2017. The RN e-mailed the DOC the next morning at 0502 hours; however, the DOC did not receive the e-mail until they returned to the home three days later, when they reported the incident to the Director, three days after the incident occurred. In an interview with the DOC on July 6, 2017, they indicated that it was the expectation of the home that the registered staff member would alert the manager that was on-call that evening, who would then notify the Director; however, confirmed that this was not done. The home's abuse policy was not complied with. [s. 20. (2)]

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**WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining**

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:**
**1. Restrained, in any way, for the convenience of the licensee or staff. 2007, c. 8, s. 30. (1).**
**2. Restrained, in any way, as a disciplinary measure. 2007, c. 8, s. 30. (1).**
**3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
**4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**
**5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that no resident of the home was restrained by the use of a physical device, other than in accordance with section 31.

Resident #001 was observed seated in a wheelchair with a physical device fastened during the course of this inspection. Review of the written plan of care identified that on an identified day in October 2016, they required the device as a restraint. Review of the Least Restraint Assessment Form, Initial and Quarterly which included restraint alternatives identified that it was completed on an identified day in February 2017. Interview with RN #104 stated the resident required the device as a restraint since an identified day in October 2016, there was a physician's order and the substitute decision maker (SDM) consented; however, confirmed there was no initial least restraint assessment completed prior to the resident being restrained with the physical device. [s. 30. (1) 3.]

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**WN #10: 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. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that a PASD described in subsection (1) was used to assist a resident with a routine activity of living only if the use of the PASD was included in the plan of care.

On an identified day in June 2017, resident #002 was observed sitting in their wheelchair tilted. Review of the plan of care did not identify the resident was positioned in a tilt wheelchair. Interview with PSW #106 stated the resident was seated in a tilt wheelchair for repositioning and comfort. Interview with RPN #108 stated that the resident required a tilt wheelchair as a PASD and confirmed it was not documented in the plan of care until it was brought to the home's attention by the Long Term Care Homes Inspector. [s. 33. (3)]

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**Issued on this 8th day of September, 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) :** | DIANNE BARSEVICH (581), JESSICA PALADINO (586), LESLEY EDWARDS (506), LISA BOS (683) |
| **Inspection No. / No de l'inspection :** | 2017_573581_0009 |
| **Log No. / No de registre :** | 011833-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Aug 3, 2017 |
| **Licensee / Titulaire de permis :** | REVERA LONG TERM CARE INC.<br>5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000 |
| **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:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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).

**Order / Ordre :**

The licensee shall:
A. Create, submit and implement a plan a plan to immediately recruit and hire Registered Nurses (RN) who hold the position as an employee of the licensee and a member of the regular nursing staff.
B. Identify strategies to maximize recruitment and retention of Registered Nursing staff
C. Ensure that a RN who is an employee of the home is scheduled to work in the home and on duty and present at all times except as provided for in the regulations.

The plan shall be submitted to dianne.barsevich@ontario.ca. no later than end of business day on September 1, 2017.

**Grounds / Motifs :**

1. This order is based upon three factors where there has been a finding of non-compliance in keeping with section 299(1) of Ontario Regulation 79/10, scope, severity and a history of non-compliance. The scope of the noncompliance is isolated (1), the severity of the non-compliance has minimal harm or potential for actual harm (2) and the history of non-compliance under s. 15(1) of Ontario Regulation 79/10 is ongoing (4) with a VPC issued in May 2017.

The licensee failed to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was 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.)

Review of the registered nursing staffing schedule from April 1 to July 6, 2017, identified that a Registered Nurse (RN) that was a member of the regular nursing staff was not on duty on the following dates:
i. On April 5 and 9, 2017, on evening shift.
ii. On April 21, 22, 24 and 25, 2017, on night shift.
iii. On April 15, 16, 2017, on day shift.
iv. On May 16, 17, 20, 21, 27 and 29, 2017, on evening shifts.
v. On June 1, 16, 19, 22 and 24, 2017, on evening shift.
vi. On June 23, 2017, on night shift.
vii. On July 1 and 2, 2017, on evening shift.

Interview with the DOC stated there was no RN in the building on April 9 and 15, 2017 on day shift and on May 16, 27, 29, June 16, 19 and 24, 2017, on evening shift and that agency RN staff was present on the other shifts listed above. The DOC confirmed that the home was unable to staff those shifts with an RN who was an employee of the home. (586)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 01, 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 August, 2017**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Dianne Barsevich

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