Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 9, 2013	2013_201167_0034	H-000739-13	Follow up

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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

MARILYN TONE (167), MICHELLE WARRENER (107)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 12, 13, 14, 15, 18, 19, 20, 21, 22, 2013

This inspection was initiated as a follow up to the following previously issued orders:
[O.Reg 79/10] s.34(1) issued March 15, 2013 (Inspection 2013_105130_0007) and again August 23, 2013 (Inspection 2013_105130_0007).
[LTCHA, 2007 S.O. 2007, c.8] s.6(1) issued August 23, 2013 (Inspection 2013_208141_0017)
Compliance Orders issued on August 23, 2013 (Inspection 2013_208141_0016):
[LTCHA, 2007 S.O. 2007,c.8] s.3(1), s. 6(10)b, s. 86(2)
[O.Reg. 79/10) s. 31(3], s. 53(2), s. 71(3), s. 73(1), s. 73(2)s. 213(1)

This inspection was conducted simultaneously with a follow up inspection conducted by the Environmental Inspector. Areas of non-compliance O.Reg. s.87(2)related to equipment and furnishings, s.88(2) related to housekeeping and LTCHA s. 86(2) related to Infection Control were issued on environmental report # 2013_189120_0082.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Executive Director (ED), the Resident Assessment Instrument Coordinator (RAI Coordinator), the Resident Services Coordinator, registered staff, personal support workers, housekeeping staff, the Nutrition Manager, the Registered Dietitian, dietary aides, residents and family members.

During the course of the inspection, the inspector(s) conducted a review of the health files for identified residents, reviewed relevant policies and procedures, observed care and meal service and conducted tours of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Infection Prevention and Control
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 care set out in the plan of care was not based on an assessment of the resident and the needs and preferences of that resident.
A) Resident #007 had a preference for consistently missing an identified meal. This preference was not identified on the resident's plan of care and an assessment of the resident's needs in relation to skipping the meal was not completed. The plan of care did not include strategies to ensure the resident was meeting their nutritional needs

while missing the meal. The resident did not meet their hydration requirement on any day over a 15 day period.
B) Resident #056 consistently preferred to skip an identified meal service. This preference was not identified on the resident's plan of care until the inspector inquired during the inspection. Strategies were not in place to ensure the resident was meeting their nutrition/hydration requirements despite missing the meal. The resident had missed the meal 25 days over a one month period.
C) Resident #051 was consistently missing an identified meal, however, this was not identified on the resident's plan of care with strategies in place to accommodate this preference. The resident had not taken the identified meal on 22 days (as per the food and fluid intake records) over a one month period. The resident had not met their hydration requirement on any day over a 15 day period (average of 32% of hydration requirement).
D) Resident #052 did not routinely come to the dining room for an identified meal. The resident's plan of care did not identify this need/preference. The resident was receiving tray service for most of the identified meals as per the resident's preference. [s. 6. (2)]

2. Staff did not collaborate with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.
A) Resident #052 had different direction for staff identified on the plan of care related to oral care. The resident's plan identified that oral care was to be provided both twice daily and also three times daily after meals. Staff confirmed they were not aware that the resident required oral care more frequently than twice daily and the resident was receiving oral care only twice daily. Staff did not collaborate in the development and implementation of the plan for oral care to ensure consistent care was provided to the resident.
B) The plan of care related to assistance with eating was not consistent for resident #057. The resident's plan of care identified set up assistance only as well as extensive assistance required for eating. At the observed meals the resident required staff assistance, prompting and/or full feeding assistance. Staff confirmed that the direction on the plan of care was not consistent. [s. 6. (4) (b)]

3. The care set out in the plan of care was not provided to residents as specified in their plans.
A) Resident #026 had a plan of care not to provide certain items at meals. These items were provided at the supper meal November 19, 2013. Staff confirmed the

resident was not supposed to receive those items.
B) At the lunch meals November 14, 16 and the breakfast meal November 16, 2013, all thickened fluids were served as honey thickened consistency. Several residents of the home required either a nectar consistency (less thick) or pudding consistency (more thick) and did not receive the correct consistency of thickened fluids. Staff confirmed only one consistency of thickened fluid was prepared at those meals. The home purchases their thickened fluids, however, the fluids come into the home in a honey consistency and staff were required to either thin the fluids or thicken the fluids if a different consistency than honey was required.
C) At the morning snack pass November 19, 2013:
i) Resident #020 required a special snack according to their plan of care. The special snack was not available on the snack cart and was not offered to the resident.
ii) Residents # 067, # 068, # 007 and # 070 who required a diabetic diet were provided regular gingerale (diet gingerale was available on the snack cart and regular had not been requested by the residents)
iii) Resident # 069 was on a regular diet and did not request diet but was provided diet gingerale.
D) Resident #052 required a special item at the breakfast meal, however, staff confirmed they were not providing it as per the resident's plan of care. The resident stated they would like the item at the breakfast meal when asked by the inspector. [s. 6. (7)]

4. The licensee did not ensure that the effectiveness of resident # 005's plan of care related to their identified behaviour was documented.
A) On an identified date during this review, the resident was noted to have displayed the identified behaviour.
B) During an interview with a personal support worker (PSW), it was confirmed that the resident regularly displayed this behaviour. It was also confirmed that this had been an ongoing problem with the resident. The PSW indicated that staff attempt to manage the resident's behaviour using the interventions noted in the resident's plan of care but the resident frequently did not cooperate. Staff attempt to check on the resident frequently to observe for signs that they may demonstrate the behaviour but this was not always effective.
C) It was noted that the document that the home refers to as the care plan for resident # 005 that was in place at the time of the review, identified the resident's behaviour and there were identified interventions in place, but the Resident Assessment Protocols and Summary for the resident did not address the resident's identified behaviour or the effectiveness of interventions in place to manage this behaviour. [s.

6. (9) 3.]

5. The plan of care for resident # 003 was not reviewed and revised when their care needs changed upon return from hospital.
A) On an identified date in 2013, resident # 003 was admitted to hospital.
B) Upon the resident's return from hospital, the Safety Assessment Lifts and Transfers Assessment and the physiotherapy assessment completed for the resident both confirmed that the resident had a significant change in their ability to transfer safely. The document that the home refers to as the care plan was not updated to include this change in the resident's ability to transfer until almost three weeks after their return.
C) While the resident was still in hospital, the progress notes indicated that staff at the hospital had informed the home that the resident had impaired skin integrity. The documentation in the resident's progress notes and the head to toe assessment completed after their return from hospital confirmed that the resident still had the impaired skin integrity. The care plan for resident # 003 was never updated to include any mention of the impaired skin integrity.
D) When resident # 003 was in hospital, an assessment was completed and a special diet was recommended upon their return to the home. The care plan was not updated to reflect the change in the resident's diet until almost three weeks after their return to the home. [s. 6. (10) (b)]

6. Residents were not re-assessed and their plan of care reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.
A) Resident #053 had a change in status and required a special therapy after returning from hospital. The resident was observed receiving the therapy during this inspection, however, the resident's plan of care was not revised to include this requirement.
The resident's plan of care was also not reassessed and their plan of care reviewed and revised after a change in hydration. The resident was flagged for poor intake over six meals twice in one month. The last Dietitian assessment was two months prior. The Dietitian confirmed that a dietary referral was not completed or received related to the poor intake.
B) Resident #062 had a significant weight gain of 32.8% in one year and 16.4% in 6 months. The resident's plan of care was not revised in relation to the ongoing weight gain (reviewed five months of records). The resident had a goal to avoid weight gain, however, despite ongoing further weight gain, nutritional interventions were not revised.

C) Resident #065 had a goal for weight maintenance within their goal weight range. The goal identified on plan of care had not been revised when the resident fell below this goal two years prior. The resident had not been within their goal weight range since that time.
D) Resident #020 had a goal for weight maintenance within their goal weight range. The goal had not been revised when the resident fell below their goal weight range. The resident had not been within their goal weight range for over one year.
E) Resident #007 had a reduction in their hydration, however, their plan of care was not revised to address the poor hydration. The resident was noted to be consistently missing a meal and was not meeting their hydration requirement. At the nutritional quarterly review, the resident was noted to be taking 74% of their required fluid needs. The previous quarter the resident was consuming an average of 86% of their required fluid needs. The plan of care was not revised when the resident had a reduction in their hydration and strategies were not in place on the resident's plan of care to address meeting the resident's needs when skipping a meal service. The resident had not met their fluid requirement on any day over a 15 day period.[s. 6. (10) (b)]

Additional Required Actions:

CO # - 001, 002 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 a) the care set out in the plan of care for each resident is based on an assessment of the resident and the needs and preferences of each resident [6(2)]; b) staff collaborate with each other in the development and implementation of the plan of care so that different aspects of care are integrated and consistent with each other [6(4)b]; c) that effectiveness of residents' plans of care are documented [6(9)3]., to be implemented voluntarily.

WN #2: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. 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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. A process was not in place to ensure that other staff assisting residents were aware of the residents' diets, special needs and preferences, including residents and their required diets. A list was not attached to the snack cart at the morning snack pass on November 19, 2013 in an identified wing of the home (a list was available on the other cart). The staff confirmed they would not know what diets residents were on unless they had the list or knew the residents well. Errors were noted in the snack pass (residents requiring diabetic diets were served regular gingerale (diet was on the snack cart and residents had not requested regular gingerale). The Nutrition Manager was informed on November 19, 2013, however, the cart did not have a resident diet list again on November 21, 2013 in the afternoon. [s. 73. (1) 5.]

2. Not all meals were served course by course unless otherwise indicated by the resident or their assessed needs.
A) At the lunch meal November 12, 2013, residents #066 and #062 were served their dessert while they were still consuming their entree. The residents did not have a

plan of care that directed staff to provide courses at the same time.
B) At the breakfast meal November 16, 2013, resident #067 was consuming their hot cereal when their hot entree was placed on the table. The resident was a slow eater and dietary staff leave the kitchen to serve in the retirement home so the entree was provided prior to when the resident was ready for the meal. The resident was still consuming their hot cereal at 0925 hours.
C) At the lunch meal November 16, 2013, food was placed on the table prior to assistance being provided for resident #052. Staff consistently feed one resident at the table and then the next resident, however, food was placed in-front of the resident while they were waiting for the other resident to be fed. [s. 73. (1) 8.]

3. Not all residents were provided with eating aides, assistive devices, personal assistance and encouragement required to eat and drink.
A) At the lunch meal November 12 and the breakfast meal November 18, 2013, resident #056 was not provided encouragement or cueing during the meal. The resident had a plan of care that required oversight or cueing, however, cueing was not provided and the resident ate poorly at the meal. The Registered Dietitian stated during interview that the resident often says they don't want the food, however, if staff encouraged the resident enough, the resident would eat.
B) At the breakfast meal November 19, 2013, resident # 057 was not provided assistance with eating until 40 minutes after the start of the meal. Food was placed in front of the resident, however, assistance was not provided until 40 minutes later. According to the resident's plan of care they required extensive assistance and assistive devices at meals, however, the devices were not provided at any of the observed meal services. Multiple staff were unaware of the need for the assistive devices and confirmed the devices were consistently not being provided to the resident. The resident asked for assistance with eating, however, staff assisting at the next table (staff assisting only 1 resident each) did not come to provide the assistance for 20 minutes and the food was not heated up for the resident.
C) At the breakfast meal November 19, 2013, resident #008 was not verbally prompted between over a 40 minute time period. The resident sat sleeping in front of their entree. Staff provided verbal encouragement after 40 minutes and the resident responded by taking more of their entree at that time. The resident's plan of care indicated they required supervision, oversight and cueing and that staff have to remind the resident that food is in front of them and encourage them to complete the meal.
D) At the breakfast meal November 19, 2013, resident #058 did not receive prompting or assistance with their meal. The resident's plan of care required limited assistance on days when they are alert, however, some days resident required total feeding to

ensure adequate intake. The resident did not consume their meal or fluids.
E) Resident #059 required limited assistance by guided maneuvering of limbs or other non-weight bearing assistance during meals. At the breakfast meal November 19, 2013, the resident was not eating and was not prompted for a 30 minute period. After 30 minutes, staff sat down with the resident and the resident started to eat. The resident ate and drank poorly at the meal.
F) Resident #013 sat for a 30 minute period in front of their entree and fluids without eating and without staff prompting. Staff came and prompted the resident after 30 minutes and the resident consumed more of their fluids.
G) At the breakfast meal November 16, 2013, resident #062 was not assisted with their meal. The resident required limited assistance by guided maneuvering of limbs, however, assistance was not provided and the resident was still consuming their cereal at 0925 hours while their entree was sitting on the table getting cold. [s. 73. (1) 9.]

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 a process is in place to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences and to ensure that all meals were served course by course unless otherwise indicated by the resident or their assessed needs., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The home did not ensure that there were sufficient food service workers for the home to meet the minimum staffing hours.
A) The required minimum staffing hours for food service workers was 65.25 hours per day or 456.75 hours per week. The home was providing 63 hours per day or 441 hours per week. A shortfall of 2.25 hours per day or 15.75 hours per week of food service worker hours was identified based on provision of 3 meals per day for 79 Long Term Care Home Residents and 66 Retirement Home residents. Staff for the Long Term Care Home prepare, distribute, clean, and receive for the Retirement Home meal services. The Administrator confirmed the calculations were correct.
B) Resident #003 was not served dessert at the lunch meal November 12, 2013 and was almost not served an entree at the breakfast meal November 19, 2013. Dietary staff leave the kitchen to go and serve in the retirement home after half an hour. The resident was a slow eater and required these items past the time that the dietary staff were in the kitchen. [s. 77. (1)]

Additional Required Actions:

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

WN #4: 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. Medications were not stored in a medication cart that was secure and locked on two identified dates during this review.
A) On the first occasion, the medication cart was left unattended and unlocked outside of a resident's room while care was being provided in the room. The inspector was able to open the drawers of the medication cart without staff becoming aware. When the staff returned to the cart and the inspector identified the unlocked cart and the staff then proceeded to go back into the room without locking the cart.
B) On the second occasion, the medication cart was left unattended and unlocked by the nursing station. The registered staff was providing medications to another resident in a room without a visual sightline of the medication cart. The inspector was able to open the cart and the narcotic medication bin inside the cart without the staff member becoming aware. The registered staff confirmed that they were aware the cart had been unlocked and unattended. [s. 129. (1) (a) (iii)]

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 drugs are stored in an area of the medication cart that is secure and locked at all time when not in use., to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 213. (1)	CO #009	2013_208141_0016	167
LTCHA, 2007 S.O. 2007, c.8 s. 3. (1)	CO #001	2013_208141_0016	167
O.Reg 79/10 s. 31. (3)	CO #004	2013_208141_0016	167
O.Reg 79/10 s. 34. (1)	CO #001	2013_105130_0007	167
O.Reg 79/10 s. 34. (1)	CO #002	2013_208141_0017	167
O.Reg 79/10 s. 53. (2)	CO #005	2013_208141_0016	167
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2013_208141_0017	167
O.Reg 79/10 s. 71. (3)	CO #006	2013_208141_0016	107
O.Reg 79/10 s. 73. (2)	CO #008	2013_208141_0016	107

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

Issued on this 10th day of December, 2013

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

Marilyn Love

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARILYN TONE (167), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2013_201167_0034
Log No. / Registre no:	H-000739-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 9, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
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:

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) (b)

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 that ensures the care set out in the plan of care is provided to residents as specified in the plan, including residents #026, #020, #052, and those residents requiring thickened fluids and diabetic menus. The plan is to be submitted by December 30, 2013 to Long Term Care Homes Inspector, Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. [LTCHA, 2007, S.O. 2007, c.8, s. 6(7)] Previously issued October 23, 2012 as a WN; February 26, 2013 as a VPC

The care set out in the plan of care was not provided to residents as specified in their plans.
A) Resident #026 had a plan of care not to provide certain items at meals. These items were provided at the supper meal November 19, 2013. Staff confirmed the resident was not supposed to receive those items.
B) At the lunch meals November 14, 16 and the breakfast meal November 16, 2013, all thickened fluids were served as honey thickened consistency. Several residents of the home required either a nectar consistency (less thick) or pudding consistency (more thick) and did not receive the correct consistency of thickened fluids. Staff confirmed only one consistency of thickened fluid was prepared at those meals. The home purchases their thickened fluids, however, the fluids come into the home in a honey consistency and staff were required to either thin the fluids or thicken the fluids if a different consistency than honey was required.
C) At the morning snack pass November 19, 2013:
i) Resident #020 required a special snack according to their plan of care. The special snack was not available on the snack cart and was not offered to the resident.
ii) Residents # 067, # 068, # 007 and # 070 who required a diabetic diet were provided regular gingerale (diet gingerale was available on the snack cart and regular had not been requested by the residents)
iii) Resident # 069 was on a regular diet and did not request diet but was provided diet gingerale.
D) Resident #052 required a special item at the breakfast meal, however, staff confirmed they were not providing it as per the resident's plan of care. The resident stated they would like the item at the breakfast meal when asked by the inspector. [s. 6. (7)] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2013_208141_0016, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that residents, including residents #003, #053, #062, #065, #020, and #007, were reassessed and their plans of care reviewed and revised when their care needs changed or the care was no longer necessary in relation to changes in condition post return from hospital, transferring, skin integrity, diet order changes, health status changes, weight changes, and changes in hydration and goals identified on the plan of care.

Grounds / Motifs :

1. Residents were not re-assessed and their plan of care reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.
A) Resident #053 had a change in status and required a special therapy after returning from hospital. The resident was observed receiving the therapy during this inspection, however, the resident's plan of care was not revised to include this requirement.
The resident's plan of care was also not reassessed and their plan of care reviewed and revised after a change in hydration. The resident was flagged for poor intake over six meals twice in one month. The last Dietitian assessment was two months prior. The Dietitian confirmed that a dietary referral was not completed or received related to the poor intake.

B) Resident #062 had a significant weight gain of 32.8% in one year and 16.4% in 6 months. The resident's plan of care was not revised in relation to the ongoing weight gain (reviewed five months of records). The resident had a goal to avoid weight gain, however, despite ongoing further weight gain, nutritional interventions were not revised.
C) Resident #065 had a goal for weight maintenance within their goal weight range. The goal identified on plan of care had not been revised when the resident fell below this goal two years prior. The resident had not been within their goal weight range since that time.
D) Resident #020 had a goal for weight maintenance within their goal weight range. The goal had not been revised when the resident fell below their goal weight range. The resident had not been within their goal weight range for over one year.
E) Resident #007 had a reduction in their hydration, however, their plan of care was not revised to address the poor hydration. The resident was noted to be consistently missing a meal and was not meeting their hydration requirement. At the nutritional quarterly review, the resident was noted to be taking 74% of their required fluid needs. The previous quarter the resident was consuming an average of 86% of their required fluid needs. The plan of care was not revised when the resident had a reduction in their hydration and strategies were not in place on the resident's plan of care to address meeting the resident's needs when skipping a meal service. The resident had not met their fluid requirement on any day over a 15 day period.[s. 6. (10) (b)] (107)

2. [LTCHA, 2007, S.O. 2007, c.8, s. 6(10)(b)] Previously issued October 23, 2012 as a VPC; February 26, 2013 as a VPC; August 26, 2013 as a CO

The plan of care for resident # 003 was not reviewed and revised when their care needs changed upon return from hospital.
A) On an identified date in 2013, resident # 003 was admitted to hospital.
B) Upon the resident's return from hospital, the Safety Assessment Lifts and Transfers Assessment and the physiotherapy assessment completed for the resident both confirmed that the resident had a significant change in their ability to transfer safely. The document that the home refers to as the care plan was not updated to include this change in the resident's ability to transfer until almost three weeks after their return.
C) While the resident was still in hospital, the progress notes indicated that staff at the hospital had informed the home that the resident had impaired skin integrity. The documentation in the resident's progress notes and the head to toe

assessment completed after their return from hospital confirmed that the resident still had the impaired skin integrity. The care plan for resident # 003 was never updated to include any mention of the impaired skin integrity.
D) When resident # 003 was in hospital, an assessment was completed and a special diet was recommended upon their return to the home. The care plan was not updated to reflect the change in the resident's diet until almost three weeks after their return to the home. [s. 6. (10) (b)] (167)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2014

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2013_208141_0016, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that all residents, including residents #056, 057, 008, 058, 059, 013, 062, are provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

Grounds / Motifs :

1. [O.Reg. 79/10, s. 73(1)9] Previously issued August 26, 2013 as a CO s. 153(1)(a)

Not all residents were provided with eating aides, assistive devices, personal assistance and encouragement required to eat and drink.
A) At the lunch meal November 12 and the breakfast meal November 18, 2013, resident #056 was not provided encouragement or cueing during the meal. The resident had a plan of care that required oversight or cueing, however, cueing was not provided and the resident ate poorly at the meal. The Registered Dietitian stated during interview that the resident often says they don't want the food, however, if staff encouraged the resident enough, the resident would eat.
B) At the breakfast meal November 19, 2013, resident # 057 was not provided assistance with eating until 40 minutes after the start of the meal. Food was placed in front of the resident, however, assistance was not provided until 40 minutes later. According to the resident's plan of care they required extensive assistance and assistive devices at meals, however, the devices were not provided at any of the observed meal services. Multiple staff were unaware of the need for the assistive devices and confirmed the devices were consistently not being provided to the resident. The resident asked for assistance with eating, however, staff assisting at the next table (staff assisting only 1 resident each) did not come to provide the assistance for 20 minutes and the food was not heated up for the resident.
C) At the breakfast meal November 19, 2013, resident #008 was not verbally prompted between over a 40 minute time period. The resident sat sleeping in front of their entree. Staff provided verbal encouragement after 40 minutes and the resident responded by taking more of their entree at that time. The resident's plan of care indicated they required supervision, oversight and cueing and that staff have to remind the resident that food is in front of them and encourage them to complete the meal.
D) At the breakfast meal November 19, 2013, resident #058 did not receive prompting or assistance with their meal. The resident's plan of care required limited assistance on days when they are alert, however, some days resident required total feeding to ensure adequate intake. The resident did not consume

their meal or fluids.
E) Resident #059 required limited assistance by guided maneuvering of limbs or other non-weight bearing assistance during meals. At the breakfast meal November 19, 2013, the resident was not eating and was not prompted for a 30 minute period. After 30 minutes, staff sat down with the resident and the resident started to eat. The resident ate and drank poorly at the meal.
F) Resident #013 sat for a 30 minute period in front of their entree and fluids without eating and without staff prompting. Staff came and prompted the resident after 30 minutes and the resident consumed more of their fluids.
G) At the breakfast meal November 16, 2013, resident #062 was not assisted with their meal. The resident required limited assistance by guided maneuvering of limbs, however, assistance was not provided and the resident was still consuming their cereal at 0925 hours while their entree was sitting on the table getting cold. [s. 73. (1) 9.] (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2014

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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks;
(b) the distribution and service of resident meals;
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures there are sufficient food service workers for the home to meet the minimum required food service worker staffing hours. The plan is to be submitted by December 30, 2013 to Long Term Care Homes Inspector, Michelle Warrener at: Michelle.Warrener@ontario.ca

Grounds / Motifs :

1. The home did not ensure that there were sufficient food service workers for the home to meet the minimum staffing hours.
A) The required minimum staffing hours for food service workers was 65.25 hours per day or 456.75 hours per week. The home was providing 63 hours per day or 441 hours per week. A shortfall of 2.25 hours per day or 15.75 hours per week of food service worker hours was identified based on provision of 3 meals per day for 79 Long Term Care Home Residents and 66 Retirement Home residents. Staff for the Long Term Care Home prepare, distribute, clean, and receive for the Retirement Home meal services. The Administrator confirmed the calculations were correct.
B) Resident #003 was not served dessert at the lunch meal November 12, 2013 and was almost not served an entree at the breakfast meal November 19, 2013. Dietary staff leave the kitchen to go and serve in the retirement home after half an hour. The resident was a slow eater and required these items past the time that the dietary staff were in the kitchen. [s. 77. (1). (107)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 9th day of December, 2013

Signature of Inspector / Signature de l'inspecteur : Marilyn Tone

Name of Inspector / Nom de l'inspecteur : MARILYN TONE

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