Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2015	2015_389601_0016	O-002285-15	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée

REACHVIEW VILLAGE
130 REACH STREET UXBRIDGE ON L9P 1L3

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

KARYN WOOD (601), CHANTAL LAFRENIERE (194), KELLY BURNS (554), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 6,7,8,9,10,13,14,15,16,17, 2015.

Critical Incident's included in the inspection were Logs #O-001438-14, #O-001196-14, #O-002323-15, #O-001400-14, #O-1399-14, #O-001437-14, #O-002445-15, #O-001118-14, #O-001273-14, #O-001027-14, #O-001092-14, #O-001997-14, #O-002028-15, #O-002034-15, #O-002029-15, O-002474-15.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Acting Director of Care (ADOC), Resident Service Co-ordinator (RSC),Regional Clinical Consultant(RCC),Food Service Manager (FSM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (ESM), Housekeeping staff, RAI Co ordinator (RAI-C),Medical Officer of Health Representative, President of Resident and Family Councils, Residents and Family members.

Also completed during the inspection,the inspector(s) toured the home, observation of medication administration, dining service, infection control practices, staff/resident provision of care. Reviewed identified clinical health records, internal abuse investigations, staff educational records, maintenance records, applicable policies, resident and family council minutes, re-admission from hospital, Physician's book, and critical incident reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **15 WN(s)**
- **8 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. s. 229(2)(e)that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During an interview, the ADOC and RCC indicated that an annual evaluation of the infection control program 2014 was not available. It was indicated the annual evaluation of the infection control program was completed for 2014, but they were not able to locate related to recent changes in the Director of Care role. (601)[s. 229. (2) (e)]

2. The licensee failed to comply with O. Reg.s. 229(4) when staff did not participate in the implementation of the infection prevention and control program.

During the course of stage #1 of the RQI, Inspector's #194, #554, #570, and #601 observed eleven residents' in the home to be exhibiting respiratory symptoms. On two identified dates,Inspector's #194 and #601 discussed concerns with the ADOC related to a number of residents in the home with respiratory symptoms. The home was not identified as being in a respiratory outbreak, at that time.

Also, during the course of the inspection it was noted the 24 hour progress notes for residents' in the home were not consistently identifying the presence of respiratory infection.

On an identified date, Inspector #194 observed Resident #3 with a congested cough. Resident #3 indicated a cough has been present for three weeks, and it was not being

treated. On the identified date there was no identified method for monitoring symptoms of infection for Resident #3.

On an identified date, Inspector #601 observed Resident #11 with a harsh cough, and Resident #11 indicated the cough was not being treated. The following day, RPN#103 indicated that Resident #11 has always had a cough, but the cough had increased in the past few days. On the two identified date's, there was no identified method for monitoring symptoms of infection for Resident #11.

On an identified date, Inspector #601 observed Resident #18 with a cough, and nasal discharge. On the identified date there was no identified method for monitoring symptoms of infection for Resident #18.

On an identified date, Inspector #601 observed Resident #47 with a productive cough, yellow phlegm, and nasal congestion. Resident #47 indicated having a cold for the past three weeks. PSW#101 indicated that Resident #47 has had a cough, nasal congestion, and lethargy for over two weeks. On the identified date there was no identified method for monitoring symptoms of infection for Resident #47.

On an identified date, Inspector #601 observed Resident #48 with a harsh cough. PSW#101 indicated Resident #48 had a cough, and had been lethargic for over a week. On the identified date there was no identified method for monitoring symptoms of infection for Resident #48.

During an interview with Inspector #194 and #601, the ADOC indicated the home did have a system in place to monitor the presence of infection for residents every shift. The current practice to identify the presence of infections in the home is to rely on registered staffs’ documentation in the 24 hour progress notes. The ADOC indicated the current practice to effectively identify the presence of infection in the home needs to be reviewed.

Review of the Policy "Infection Surveillance and Reporting" IPC-J-10-ON directs:
-Each home shall submit infection surveillance reports to their local Public Health departments as per jurisdictional requirements-The infection data for surveillance purposes shall be collected using the recommended case definitions from best practices for Surveillance of Health-Associated Infections (PIDAC) October 2011

The unit Nurse/designate will:-Be responsible for documenting signs and symptoms of

infection in the Resident's Interdisciplinary Progress Notes (IPN)
-Complete the Resident Home Area Daily Infection Control Surveillance Form (IPC-J-10-15-ON)

The Home's Infection Control Coordinator/Designate will:
-Collect, verify and organize data received from unit nurse regarding all types of infections using Best Practices for Surveillance of Health Care-associated infections (PIDAC) October
-Analyze the data collected to determine whether an infection exists
Infection patterns that may be detected include:
-Types of infections
-Areas within the Home that may be experiencing a rise in the baseline number of Residents with a certain type of infection
-Infections caused by a similar microorganism
-Infections that have occurred in a similar time frame, associated with certain procedures/equipment
-Analysis shall be done as frequently as necessary, but at least monthly, in order to intervene as appropriate

During this inspection the Public Health unit was contacted by Inspector #601 to report a potential respiratory outbreak in the home. The Medical Officer of Health Representative visited the home. It was determined that fourteen residents including Resident #3, 11, 18, 47, and 48 had respiratory symptoms, and were placed on the homes respiratory line listing. The Public Health Unit declared the home to be in a respiratory outbreak following the inspection.

On an identified date, Resident #3, 11, 18, 47, 48, were identified by the home as having respiratory symptoms, and were placed on the homes Respiratory Line Listing.

Related to the use of personal protective equipment as per policy and best practice:

On an identified date, Resident #47 and #49 were exhibiting respiratory symptoms. PSW#101 indicated face masks and gowns were not being used while providing personal care.

On an identified date, Resident #33 was exhibiting respiratory symptoms. PSW#111 indicated face masks and gowns were not being used while providing personal care.

On two identified date's, Resident #46 who resides in an identified room was noted to be on the Respiratory Outbreak line listing. There was no signage related to droplet precautions noted on the doorway of the four bed shared accommodation. (601)[s. 229. (4)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

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

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s.6(1)(a), by not ensuring the plan of care for Resident #46, set out the planned care specific to communication and assistive devices.

Resident #46 is dependent on staff for all activities of daily living.

During an interview with Resident #46's SDM, it was indicated while visiting Resident #46 it was observed that Resident #46 has not been wearing assistive devices, and on one occasion the assistive device was being used by another resident. SDM indicated they have not seen staff providing Resident #46 with assistance to use a communication device. Resident #46 uses the communication device to communicate needs. SDM indicated that staff were not aware of Resident #46's cues to communicate the need to use the toilet.

A review of the clinical record including the current plan of care related to assistive devices for communication did not provide direction related to Resident #46 requiring the application of assistive devices for communication aid.

During an interview, PSW #116 who works full-time on Resident #46's unit, indicated no awareness of Resident #46's need to use assistive devices to navigate and aid communication.

During an interview, the ADOC and RN indicated the expectation is that staff are aware of Resident #46 care needs, and the plan of care is reflective of the resident's care needs so that staff know how to provide care for the resident.(554) [s. 6. (1) (a)]

2. The licensee has failed to comply with LTCH, 2007, s.6.(5) by not ensuring that Resident #3 was provided the opportunity to participate fully in the development and implementation of the plan of care.

During an interview, Resident #3 indicated that a cough has been present for the past three weeks, and was not assessed by the Physician, as requested. Resident #3 is capable of making decision regarding personal care.

During an interview, the RSC and RPN#104 indicated about two weeks prior Resident #3 had expressed concerns about having a cough, not feeling well,requesting an assessment, and to see the Physician. The RSC and RPN#104 were not able to verify if the Physician had been notified of the resident's request to be seen, or if the Physician

had assessed the resident.

Review of the progress notes for Resident #3 does not indicate an assessment was completed by the physician during the period of three month period.

During an interview, RN #105 indicated not being aware that Resident #3 had brought forward concerns related to a cough, and wanting to see the physician. RN#105 indicated not recalling the physician seeing the resident about a cough. (194)[s. 6. (5)]

3. The licensee failed to comply with LTCHA, 2007, s. 6 (7), by not ensuring the care set out in the plan of care provided to the resident as specified in the plan, specific to continence.

Resident #30 requires the use of specific treatment.

During an interview, Resident #30 indicated that the resident's treatment was not being maintained monthly as directed.

Family member of Resident #30 indicated bringing this concern to the attention of the ADOC a week ago, indicating the ADOC stated the treatment would be completed following resident's bath; Family member and resident indicated the treatment had not been completed during the time of this inspection.

Review of the clinical health records for Resident #30 indicates a treatment order to be completed on the sixth day of each month.

Review of the Medication Administration Records (e-MAR) identified RPN #121 had signed as completing Resident #30's treatment on the sixth day of the month. However, during an interview RPN#121 indicated the treatment was not completed by RPN#121 during the identified time period. 554 [s. 6. (7)]

4. The licensee failed to comply with LTCHA. 2007, c. 8, s. 6(10)(b), by not reassessing resident and ensuring the plan of care is reviewed, and revised when Resident #32's care needs changed.

Related to Intake #O-002323-15:

Resident #32 fell twice within a three month period. As a result of the last fall, the

resident sustained an injury.

A review of the clinical records for Resident #32 from that time period, indicated no evidence of a plan of care specific to falls risk and prevention in place and no reassessment or review of care needs after the resident first fall. The plan of care was not updated to include a risk of falls or interventions to prevent falls until after the second fall that resulted in an injury.

During an interview, the ADOC and RPN #128 indicated the plan of care for Resident #32 should have been reviewed and updated after the first incident.(570) [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that Resident #46 plan of care sets out care requirements for staff as it relates to personal care items; that there be communication and collaboration between the home's staff members and physician to ensure that Resident #3 medical concerns are communicated and assessed in a timely manner;and that Resident #30 plan of care and interventions specific to continence care, and Resident #32 plan of care reflects risk for falls is, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s.15(2)(a), by not ensuring that the home, furnishings and equipment are kept clean and sanitary.

Observations during this inspection:

Privacy Curtains – visible brownish staining was seen along bottom edge of curtain and on other areas, scattered on the panel of the curtain - located in ten identified resident room(s); and in the communal male washroom and spa room (1 curtain), and a communal male washroom and spa room (2 curtains) and in the female washroom and spa room (1 curtain as enter spa area).

Safety belt – a blue safety belt attached to the (Alenti) bath chair was seen to have whitish soiling along entire length of belt.

Identified room - wall in room visibly soiled with brownish marks

During an interview, PSW #108 and RPN #109 indicated not being aware of when or how privacy curtains are cleaned if soiled; PSW #108 indicated housekeeping staff identify the need for cleaning the curtains.

During an interview, PSW #120 indicated the home only has one safety belt for each tub room; the safety belt is used for all residents requiring tub baths. PSW #120 indicated the belt is sprayed with disinfectant following baths, and then used on the next resident; no awareness if the safety belt is laundered.

During an interview, ESM indicated the current process in place is that privacy curtains are taken down and laundered upon a resident's discharge, following outbreak for those identified as being in the outbreak, and if staff communicate the need for curtains to be laundered. ESM indicated knowing of no actual policy for cleaning curtains and indicated no awareness of the privacy curtains identified above as being soiled. The ESM indicated not being aware of the process for cleaning the safety belt for the bath chair and was not sure if there were extra safety belts available if the belt required laundering.

The home's policy, General Cleaning-Cleaning Privacy Curtains (#ESP-C-230) directs that privacy curtains will be cleaned annually and as required to maintain a clean and pleasant environment. The home's policy, relating to wall cleaning (# ES C-10-05 and #

ES C-10-30) directs that resident walls will be spot cleaned as required to ensure cleanliness, control bacteria, odours and to maintain acceptable aesthetic conditions.

During an interview, the ESM indicated it is an expectation that any soiled privacy curtains and or other areas in the home that requires cleaning will be identified and will be cleaned accordingly.(554)[s. 15. (2) (a)]

2. The licensee failed to comply with LTCHA, 2007, s.15(2)(c), by not ensuring the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The following was observed during the inspection:

Walls – visibly scuffed (black marks), paint peeling, gouged or wall damage (holes, dry wall or steel beading and or mesh exposed) – located in nine identified resident room(s) and in the spa and communal washrooms.

Wall Guards – loose and or missing – located in six identified resident room(s) and in the spa-communal room.

Ceiling Tiles – brownish staining visible – hallway joining two home areas; spa-communal washroom and in the green house.

Counter-top Vanity – laminate counter top vanity observed chipped or missing – three spa/communal washroom(s).

Toilets – brownish-black staining visible at base of toilet and flooring – in spa/communal washroom(s)and in two identified residents rooms.

Flooring – tiled flooring throughout an identified hallway, especially outside of an identified room and by the two communal washrooms cracked with a few tiles noted to be chipped; laminate flooring near the door in six identified room(s)all have holes (two) in the flooring, approximately 2cm circumference; an identified room has a hole in the flooring approximately 5cm irregular shape; uneven tiled flooring (area approximately 10cm circumference) in lounge near nursing station.

Flooring – laminate flooring in the male communal washroom-spa was observed to be cracked (split) by shower wall/toileting area by tub and in one washroom; both areas

were noted to be wet and seeping onto sub-flooring beneath.

Flooring – non slip laminate flooring in spa-communal washrooms have visible brownish staining throughout.

Baseboard Heater – cover of heater not in place, sharp coils exposed – located in two identified resident room(s).

Baseboard Heater(s) – visible scuffing (black marks) or rust – eleven identified resident room(s).

Door and or Door Frames – paint chipped and or gouged areas – eleven identified resident room(s); in addition an identified room the wall guard on door is loose.

Foot Board – laminate loose – in an identified resident room.

Wardrobe (Towel Cupboard) – laminate doors are cracked with sharp edges- located in a spa room.

Upon entry into Green House, and noted along seams and corners in spa-communal washrooms have visible build-up of dust and or debris which comes off easily when scraped.

During an interview,the ESM indicated the following:
- flooring issues (tiles cracked, broken or split) not identified nor plan in place to repair
- had identified stained flooring in spa rooms, but hadn't contacted anyone as to potential resolution
- no awareness of painting schedules for resident rooms

During an interview, the ESM and RCC indicated the expectation would be that required repairs would be identified, and repaired as soon as possible. (554)[s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that procedures are developed and implemented for cleaning of the home; walls; privacy curtains; furnishings; and equipment including the safety belt for the bath chair are kept clean and sanitary, and that furnishings and equipment are maintained in a safe condition, and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCH, 2007, s.23.(2), by not ensuring the results of the abuse or neglect investigation were reported to the Director. s.23(2)

Relate to Intake #O-001437-14:

On an identified date, PSW#129 and PSW#131 heard PSW#123 yelling and belittling Resident #56. PSW#129 and PSW#131 heard Resident #56 voice, "no touch, don't touch me".

The licensee completed the internal investigation of the alleged staff to resident abuse towards Resident #56.

During an interview, the ADOC indicated the results of the investigation for Resident #56 were not reported to the Director. (601)[s. 23. (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 by ensuring that every alleged, suspected or witnessed incident, of (i) abuse of a resident by anyone, that the licensee knows of, or that is reported is immediately investigated. A written plan of correction for achieving compliance by ensuring that the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s.24(1), by not ensuring that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Related to Intake #O-001092-14:

Resident #58 was found in the morning by day staff to have a purplish bruise to the left eye; resident was weepy and teary eyed. Resident #58 was said to be anxious. Resident was unable to say what happened and or how the bruising occurred.

During an interview, the ADOC indicated the Critical Incident Report was submitted, to the Ministry of Health and Long Term Care (MOHLTC), as it's the home's practice to report any unknown injury of a resident as such could be suspicious of physical abuse. The ADOC indicated that the Director had not been immediately notified related to the allegations of abuse, specific to an unknown bruise. Critical Incident #2635-000019-14 was submitted the day after the alleged incident occurred.(554)

Related to Intake #O-001399-14:

On an identified date PSW#129 witnessed PSW#123 yell and grab Resident #50's right arm, under the arm pit, and force Resident #50 to lay down.

PSW#129 submitted to the Director of Care an allegation of staff to resident physical, verbal and emotional abuse, with no injury towards Resident #50 that occurred on an identified date.

During an interview, the ADOC indicated the Director had not been immediately notified related to the allegations of abuse. Critical Incident # 2635-000028-14 was submitted six days following the alleged incident. (601)

Related to Intake #O-001437-14:

On an identified date, PSW#129 and PSW#131 heard PSW#123 yelling and belittling Resident #56. PSW#129 and PSW#131 heard Resident #56 voice, "no touch, don't touch me".

PSW#129 and PSW#131 submitted to the Director of Care an allegation of staff to resident abuse, with no injury towards Resident #56 that occurred on an identified date.

During an interview, the ADOC indicated the Director had not been immediately notified related to the allegations of abuse. Critical Incident # 2635-000029-14 was submitted nine days following the alleged incident.(601)

Related to Intake #O-001400-14:

On an identified date, Resident #57 Substitute Decision Maker (SDM) reported observing PSW#124 apply Resident #57 lift straps roughly, bang the resident's hip hard during care, and grab the resident's leg roughly when lifting to place on the wheelchair foot rests.

During an interview, with RN#105 it was indicated that on the day of the incident Resident #57 family reported the allegations of physical and emotional abuse towards Resident #57 by PSW#124. RN#105 indicated the allegations of abuse was not reported immediately to the manager on call.

The following day, Resident #57 SDM submitted to the Director of Care an allegation of staff to resident physical, verbal and emotional abuse that occurred on an identified date and time, resulting in Resident #57 becoming visibly upset,crying, and indicating PSW #124 help was not wanted due to grabbing roughly during care.

During an interview, the ADOC indicated the Director had not been immediately notified related to the allegations of abuse. Critical Incident # 2635-000025-14 was submitted two days following the alleged incident. (601)[s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s.31.(2)4. where by the restraint plan of care does not include an order by the physician or the registered nurse in the extended class.

Resident #17 was observed on four identified dates with a front closing seat belt in place while sitting in wheelchair. Resident #17 was asked by Inspectors, RN#100, and PSW#101 on three different occasions to release the front closing seat belt, and Resident #17 was unable.

During an interview, the ADOC and RN#100 indicated that Resident #17 does not have a physician order for a seat belt restraint, as Resident #17 family did not consent to the seat belt use. RN#100 indicated that Resident #17 was not on the seat belt restraint list because Resident #17 will do the seat belt up, play with the seat belt and remove.

During an interview, PSW#101 and PSW#127 indicated that staff apply the seat belt when transferring Resident #17 to the wheelchair, but Resident #17 plays with the seat belt, and will sometimes remove independently.

Plan of care reviewed, and Resident #17 does not have a current physician order for a front closing seat belt restraint.(601) [s. 31. (2) 4.]

2. The licensee has failed to comply with LTCHA 2007, s.31.(2)5. where by the restraint plan of care does not include the consent by the resident or if the resident is incapable, by the Substitute Decision Maker.

Resident #17 was observed on four identified dates, with a front closing seat belt in place while sitting in wheelchair. Resident #17 was asked by Inspectors, RN#100 and PSW#101 on three different occasions to release the front closing seat belt, and resident was unable.

During an interview, RN#100 indicated Resident #17 family did not consent to the seat belt use, and the order for the seat belt use was discontinued by the Physician.

Plan of care reviewed, and Resident #17 does not have current consent, by the substitute decision maker for a front closing seat belt restraint. (601)[s. 31. (2) 5.]

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 where by the restraint plan of care for Resident #17 will include an order by the physician or the registered nurse in the extended class, and consent from the Substitute Decision Maker, if it is determined that a seat belt restraint is appropriate for Resident #17, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg.79/10, r.87(2)(d), by not ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Observations during this inspection:

Three identified ward rooms were noted to have pervasive malodour noted when entering the room and the odour became greater in intensity in two identified cubicle areas.

During an interview, PSW#108 and RPN#109 indicated male ward rooms within the home smell of urine; both indicated they have not reported this to anyone as it's normal for the rooms to smell. PSW #108 indicated the nursing department does use the Biological Odour Eliminator spray, but the effect of the spray is short lived. RPN #109 indicated the home possibly used charcoal to eliminate odours in an identified room, but was unsure.

During an interview, the ESM indicated being aware of male ward rooms smelling of urine, and indicated that there is currently no process in place.

The home's policy, Nova-Quality Management Urine Odour Audit (# ES C-25-15) indicates that all lingering urine odours are investigated and eliminated. The policy directs that when a concern of lingering urine odour is identified the urine odour audit form must be completed by ESM. This will include the conclusion and suggested action to eliminate the odours.

During an interview, the ESM indicated the expectation is the home would be free of odours. (554)[s. 87. (2) (d)]

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 by ensuring that procedures are developed and implemented for addressing incidents of lingering offensive odours in the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, r.107(3)3. by not ensuring to notify the Director within one business day of missing or unaccounted for controlled substances.

Relate to intake #O-002028-15:

On an identified date and time the RN noticed that Resident # 45's analgesic patch could not be located on the resident's body. A search was completed and the analgesic patch was not located.

A critical incident report was submitted to the Director twenty-two days following the incident. During an interview the ADOC indicated the time lines for submission had been missed. (194) [s. 107. (3) 3.]

2. The licensee has failed to comply with O.Reg. 79/10, r.107.(4)2. by not ensuring that the report to the Director included the names of any staff members or other persons who were present at or discovered the incident.

Related to Intake #O-001196-14 and Intake #O-002323-15:

Review of Critical Incident Reports (CIR) #2635-000017-14 involving Resident #52 who had a fall resulting in a in an injury, and #2635-000011-15 involving Resident #32 who had a fall resulting in an injury indicated the home did not include the names of Personal Support Workers who discovered the incidents that caused injury to the residents.

The ADOC confirmed the names of the PSWs who were present at or discovered the incidents were not included in the Critical Incident Report submitted to the Director. (570) [s. 107. (4) 2.]

3. The licensee failed to comply with O.Reg. 79/10, r.107(5), by not promptly notifying the designated substitute decision-maker of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified.

Related to Intake #O-001027-14:

The ADOC submitted a Critical Incident Report (CIR #2635-000018-14) for an incident resulting in Resident #22 being burned when a hot beverage that caused a burn until

seven days after the incident occurred.

A review of the progress notes indicated Resident #22's Substitute Decision Maker was not notified of the incident and resulting injuries until four days after the incident.

During an interview, the ADOC indicated the expectation is that a resident's Substitute Decision Maker,or identified family member is to be notified of resident incidents within 24 hours or sooner if resident has injuries. (554)[s. 107. (5)]

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 by ensuring to notify the Director within one business day of missing or unaccounted for controlled substances. A written plan of correction for achieving compliance by ensuring the Substitute Decision Maker is notified of the incident, and resulting injuries that are reported to the Director include the names of any staff members or other persons who were present at or discovered the incident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s.131(1) by ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Resident #35 was observed by Inspector #554 using a medical therapy. Resident #35's progress notes indicated the use of medical therapy for identified dates just over a month. Review of the clinical health record, and interview with RN#105 indicated that no Physician's order for the use of the medical therapy was obtained.

Resident #14's progress notes indicated the use of medical therapy, for identified dates consisting of three days. Review of the clinical health record, and interview with RN#105 indicated that no Physician's order for the use of the medical therapy was obtained.

Resident #34's progress notes indicated the use of a medical therapy, for identified dates consisting of four days. Review of the clinical health record, and interview with RN#105 indicated that no Physician's order for the use of the medical therapy was obtained.

Review of "Oxygen Therapy" policy LTC-F-120 directs:

- The Nurse may initiate oxygen at 1 liter per minute (lpm) via nasal canula and titrate in 1 liter per minute increments every 15 minutes until a SaO2 of 90% is achieved.
- In all circumstances of oxygen therapy the Physician/Nurse Practitioner will be contacted within 24 hours for orders including: amount of oxygen expressed in l liter per minute, duration and associated activity.

During an interview, RN #105 indicated the home's practice was to contact the Physician within 24 hours when initiating the medical therapy to residents.

During an interview, the Physician indicated the expectation was to be contacted by the nursing staff within 24 hours of initiating the medical therapy and obtain a Physician's order.

During an interview, the ADOC indicated to Inspector #570 that staff are to assess respiratory status of resident's, and if treatment is required to apply without an order, if the medical therapy is required for longer than 24 hours a Doctor's order is to be obtained. (194)[s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring the home's policy for oxygen therapy is complied with by ensuring no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007, s.3(1)1, by not ensuring the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity has been fully respected and promoted.

On an identified date a resident could be seen sitting on the toilet in the communal washroom; resident was visible to the hallway. Staff were observed walking by the washroom, and did not intervene by closing the door to the room or washroom, nor closing the privacy curtain.

On an identified date, Resident #50 was observed sitting on the toilet in a communal washroom, the door to the room, the privacy curtain inside the room and the door to the washroom were all open; a staff member was in attendance with the resident, while a second personal support worker was sitting outside the room. Resident #50 was then assisted to pull up continence product; the care being provided to Resident #50 was visible to the hallway.

During an interview, RPN #109 indicated that dignity should always be maintained, as in the case of pulling privacy curtains for residents especially those who can't speak for themselves. Also, the ADOC indicated it is an expectation that dignity of residents is maintained. (554)[s. 3. (1) 1.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10,s.13, by not ensuring each resident bedroom occupied by more than one residents' have sufficient privacy curtains to provide privacy.

The following observations were made during the inspection:

An identified room for approximately one day – no privacy curtain in place surrounding resident's bed from head of bed to foot of bed, at door side of room (area without privacy curtain is approximately 8 feet in width); this is a shared ward room.

An identified room for approximately four days – no privacy curtain from foot of bed to head of bed, window side of room (area without privacy curtain is approximately 5 feet in width); this is a shared ward room.

During an interview, PSW#108 indicated the privacy curtain missing for Resident #51 was identified during morning care, but she had not had time to notify Environmental Services Manager; Personal Support Worker and Registered Practical Nurse #109 both indicated no awareness of Resident #31 privacy curtain being absent.

During an interview, the ESM indicated not being aware of the privacy curtains in an identified room not being in place. ESM indicated no awareness of that an identified room privacy curtain panel was missing.

During an interview, the ADOC and RCC indicated that staff are to utilize privacy curtains when providing resident care; and further indicated the expectation is all resident rooms occupied by more than one resident are to have privacy curtains, to ensure privacy and dignity for residents. (554)[s. 13.]

WN #12: 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. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10, s.20.(1) by not ensuring that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with.

Log# O-001399-14:

Review of licensee's Policy "Resident Non abuse " LP-C-20-0N directs:

Mandatory Reporting:
Any staff member or persons, who becomes aware of and/or has reasonable grounds to suspect abuse or neglect of a resident must immediately report that suspicion and the information on which it is based to the executive director (ED) of the Home or, if unavailable, to the most senior supervisor on shift a that time. The person reporting the suspected abuse or neglect must follow the home's reporting requirements to ensure that the information is provided to the ED immediately.

On an identified date PSW#129 witnessed an alleged physical, verbal, and emotional abuse towards Resident #50 by PSW#123. PSW#129 did not report the allegations of physical, verbal, and emotional abuse to the most senior supervisor on shift at that time, as directed by the policy. DOC was notified two days following the incident. [s. 20. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10,s.97(1)(a), by ensuring that the resident's SDM and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of the resident that:
• resulted in a physical injury or pain to the resident, or
• caused distress to the resident that could potentially be detrimental to the resident' s health or well-being

Related to Intake #O-001118-14:

The ADOC submitted a Critical Incident Report #CIR #2365-000021-14 on an identified date for an incident of resident to resident physical abuse which was said to have occurred the same day. Resident #54 and Resident #55 were in their room when staff in hallway overheard a resident calling out; staff arrived to resident's room and found Resident #55 in bed with blood on face; Resident #55 indicated that Resident #54 had caused the injury.

Review of progress notes for the date of the incident indicated that Resident #55 had scratches on face, bruising and bleeding to right eye and the bridge of resident's nose was bleeding.

According to the clinical health record, Resident #55 has no family and to Public Guardian and Trustee (PGT) for care and financial decisions.

There is no indication in the clinical health record, nor included in the Critical Incident Report that the Public Guardian and Trustee was notified of the physical abuse incident which involved Resident #55 nor resident's injuries associated with the said incident.

During an interview, the ADOC indicated no awareness the PGT for Resident #55 had not been notified of the alleged incident.

During an interview, the ADOC and RCC indicated the expectation is that the resident's substitute decision maker or other person specified are to be notified of incidents involving alleged, suspected or witnessed abuse, especially those that result in injury. (554)[s. 97. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. s.99(e) by not ensuring that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

During an interview, the ADOC and RCC indicated that an annual evaluation of the abuse program for 2014 was not available. It was indicated the annual evaluation of the abuse program was completed for 2014, but was not able to locate related to recent changes in the Director of Care role. (601)[s. 99. (e)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s. 104 (1) 2, by ensuring that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

Related to Intake #O-001092-14:

The ADOC submitted a Critical Incident Report (CIR #2635-000019-14) for an identified date and time, specific to an unknown bruise and suspicion of physical abuse.

The Critical Incident Report failed to identify staff that were present or discovered the incident.(554)[s. 104. (1) 2.]

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 16th day of October, 2015

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

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) :	KARYN WOOD (601), CHANTAL LAFRENIERE (194), KELLY BURNS (554), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2015_389601_0016
Log No. / Registre no:	O-002285-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 27, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	REACHVIEW VILLAGE 130 REACH STREET, UXBRIDGE, ON, L9P-1L3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michael MacDonald

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 :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff participate in the implementation of the Infection Control Program:

-The designated Infection Control Co-ordinator (ICC) who has education, and experience in infection prevention and control practices as required by O. reg 79/10, s 229(3) shall co-ordinate the education for all staff to ensure they have the necessary knowledge, and understanding of infection control practices; a method for ensuring all staff adhere to the infection control practices, and a plan for re-education when ongoing knowledge deficits are identified.

-The plan should include, but not be limited to, a method and education for monitoring and responding to infectious disease symptoms each shift; daily analysis of the presence of infection to detect trends, for the purpose of reducing the incidence of infections and outbreaks; when and how to notify the Public Health Unit when suspicion of infectious disease outbreak is identified.

-Materials and contents of the education plan related to infectious diseases and control will be reviewed, and approved by a representative of the municipality of Durham Region Public Health Unit.

The licensee will provide a written plan by August 4, 2015.

This plan must be submitted in writing to the MOHLTC, Attention: Karyn Wood, Fax (613)569-9670

Grounds / Motifs :

1. The licensee failed to comply with O. Reg.s. 229(4) when staff did not participate in the implementation of the infection prevention and control program.

During the course of stage #1 of the RQI, Inspector's #194, #554, #570, and #601 observed eleven residents' in the home to be exhibiting respiratory symptoms. On two identified dates, Inspector's #194 and #601 discussed concerns with the ADOC related to a number of residents' in the home with respiratory symptoms. The home was not identified as being in a respiratory outbreak, at that time.

Also, during the course of the inspection for four identified days, it was noted the 24 hour progress notes for residents' in the home were not consistently identifying the presence of respiratory infection.

On an identified date, Inspector #194 observed Resident #3 with a congested cough. Resident #3 indicated a cough has been present for three weeks, and it was not being treated. On the identified date there was no identified method for monitoring symptoms of infection for Resident #3.

On an identified date, Inspector #601 observed Resident #11 with a harsh cough, and Resident #11 indicated the cough was not being treated. The following day RPN#103 indicated that Resident #11 has always had a cough, but the cough had increased in the past few days. On the two identified dates there was no identified method for monitoring symptoms of infection for Resident #11.

On an identified date, Inspector #601 observed Resident #18 with a cough, and nasal discharge. On the identified date there was no identified method for monitoring symptoms of infection for Resident #18.

On an identified date, Inspector #601 observed Resident #47 with a productive cough, yellow phlegm, and nasal congestion. Resident #47 indicated having a cold for the past three weeks. On the identified date, PSW#101 indicated that Resident #47 has had a cough, nasal congestion, and lethargy for over two weeks. On the identified date there was no identified method for monitoring symptoms of infection for Resident #47.

On an identified date, Inspector #601 observed Resident #48 with a harsh cough. On the identified date, PSW#101 indicated Resident #48 had a cough, and had been lethargic for over a week. On the identified date there was no identified method for monitoring symptoms of infection for Resident #48.

During an interview with Inspector #194 and #601, the ADOC indicated the home did have a system in place to monitor the presence of infection for residents every shift. The current practice to identify the presence of infections in the home is to rely on registered staffs' documentation in the 24 hour progress notes. The ADOC also indicated the current practice to effectively identify the presence of infection in the home needs to be reviewed.

Review of the Policy "Infection Surveillance and Reporting" IPC-J-10-ON directs:
-Each home shall submit infection surveillance reports to their local Public Health departments as per jurisdictional requirements-The infection data for surveillance purposes shall be collected using the recommended case definitions from best practices for Surveillance of Health-Associated Infections (PIDAC)

The unit Nurse/designate will:-Be responsible for documenting signs and symptoms of infection in the Resident's Interdisciplinary Progress Notes (IPN)
-Complete the Resident Home Area Daily Infection Control Surveillance Form (IPC-J-10-15-ON)

The Home's Infection Control Coordinator/Designate will:
-Collect, verify and organize data received from unit nurse regarding all types of infections using Best Practices for Surveillance of Health Care-associated infections (PIDAC) October
-Analyze the data collected to determine whether an infection exists
Infection patterns that may be detected include:
-Types of infections
-Areas within the Home that may be experiencing a rise in the baseline number of Residents with a certain type of infection
-Infections caused by a similar microorganism
-Infections that have occurred in a similar time frame, associated with certain procedures/equipment
-Analysis shall be done as frequently as necessary, but at least monthly, in order to intervene as appropriate

During this inspection the Public Health unit was contacted by Inspector #601 to report a potential respiratory outbreak in the home. The Medical Officer of Health Representative visited the home. It was determined that fourteen residents, including Resident #3, 22, 18, 47, and 48 had respiratory symptoms, and were

placed on the homes respiratory line listing. The Public Health Unit declared the home to be in a respiratory outbreak following the visit.

Related to the use of personal protective equipment as per policy and best practice:

On an identified date, Resident #47 and #49 were exhibiting respiratory symptoms. PSW#101 indicated face masks and gowns were not being used while providing personal care.

On an identified date, Resident #33 was exhibiting respiratory symptoms. PSW#111 indicated face masks and gowns were not being used while providing personal care.

On July 13 and July 14, 2015, Resident #46 who resides in room #17 was noted to be on the Respiratory Outbreak line listing. There was no signage related to droplet precautions noted on the doorway of the four bed shared accommodation.

The non-compliance with O. Reg, s.229(4) order was based upon the application of the factors of severity and scope in keeping with O. Reg., s.299(1). During Stage #1 of the RQI inspection in July 2015, eleven of ninety-nine residents' were identified as having symptoms of respiratory infection by the Inspectors. Therefore, there is risk for spread of infectious disease as staff had not identified, documented, analyzed, nor taken action each shift regarding respiratory symptoms. In fact, the staff did not recognize the home was in outbreak even after the Inspectors brought it to their attention, resulting in the Inspector calling Public Health Unit to report a potential respiratory outbreak. In addition, the compliance history of the home from July 28, 2014, indicates previous non-compliance related to infection prevention and control. Any, and all residents of the home are at risk for infectious diseases if the staffs do not consistently participate in the home's Infection Prevention and Control Program. (601)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Karyn Wood

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