Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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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
Dec 13, 2016	2016_433625_0018	022121-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

PINEWOOD COURT
2625 WALSH STREET EAST THUNDER BAY ON P7E 2E5

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

KATHERINE BARCA (625), LAUREN TENHUNEN (196), SARAH CHARETTE (612)

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): October 31, November 1-3 and 7-10, 2016

Additional logs inspected concurrently during this RQI were as follows:
- a Critical Incident System report the home submitted for an injury that occurred to a resident as a result of equipment breaking; and
- a Critical Incident System report the home submitted for an injury that occurred to a resident which may have been related to the provision of care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Associate Director of Care (ADOC), the Resident Assessment Instrument (RAI) Coordinator, the Environmental Services (ES) Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Maintenance Helper, residents, family members and care givers.

The Inspectors also reviewed resident health care records, several of the home's policies and procedures, the home's investigation files, Resident and Family Councils meeting minutes and invoices for products and services in the home. Inspectors completed observations of residents, observed the provision of care and services to residents, observed resident and staff interactions, home areas, meal services and conducted a tour of resident care areas.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation

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

- **8 WN(s)**
- **6 VPC(s)**
- **2 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. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During stage one of the inspection, on a day in November of 2016, resident #003, #005 and #006 stated to Inspector #196 that they were not offered a beverage between breakfast and lunch.

On another day in November of 2016, Inspector #612 observed a resident home area between 0930 hours and 1115 hours and noted that no beverage was offered to the residents on the home area.

On the same day in November of 2016, Inspector #196 observed a second resident home area between 0930 hours and 1100 hours and noted that no beverage was offered to the residents on the home area.

On another day in November of 2016, Inspector #612 observed a third resident home area between 0915 hours and 1100 hours and noted that no beverage was offered to the residents on the home area.

On a day in November of 2016, Inspector #612 interviewed Personal Support Worker (PSW) #109 and PSW #110 who stated that they were expected to offer a beverage to residents between breakfast and lunch, however they often did not have time as they were providing other care to residents. They stated that if a resident requested a beverage they would provide something to drink. PSW #109 stated if a beverage was not offered between breakfast and lunch, they would document it as not applicable in Point of Care (POC) under the per cent of snack eaten between meals.

On a day in November of 2016, Inspector #612 reviewed the documentation in POC for seven days in November of 2016, for residents #003, #005 and #006. For resident #003, the provision of a beverage between breakfast and lunch was documented as not applicable for six of the seven days, and for one day there was nothing documented. For resident #005, it was documented as not applicable for five of the seven days and on one day nothing was documented. For resident #006, six of the last seven days were documented as not applicable, and on one day nothing was documented.

The Inspector reviewed the home's policy titled "Nourishments, Supplements, and Prescribed Items" (no index number) effective August 31, 2016, which stated that a between meal nourishment would be provided as outlined in the snack menu. The policy also stated that the nourishment/snack menu cycle and delivery times were developed according to provincial regulations and Residents' Council feedback and suggestions.

On a day in November of 2016, Inspector #612 interviewed the Director of Care (DOC) who stated that staff were expected to offer the residents a beverage in the morning, between breakfast and lunch. [s. 71. (3) (b)]

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

On a day in November of 2016, Inspector #612 observed the dining service on a resident home area. The Inspector observed two of the PSWs serve clean plates to one resident, remove two dirty plates and then proceed to assist residents with eating, without washing their hands.

During the same dining service, the Inspector observed Registered Practical Nurse (RPN) #104 administer medications to four residents without washing their hands in-between the medication administration to the residents. The RPN then served a sandwich to a resident before returning to their medication cart to administer medications to another resident. The RPN touched residents' utensils and beverage cups in between administering the medications.

On another day in November of 2016, Inspector #612 observed RPN #107 on a second resident home area. The RPN assisted a resident with their mobility aid and then prepared medications and administered them to the resident, without washing their hands. The RPN then sat next to another resident, rubbed their shoulder, and administered their medication without washing their hands. As they were returning to the medication cart, RPN #107 moved a resident’s mobility aid, approached another resident and rubbed their back, and then washed their hands.

The Inspector reviewed the home's policy titled “Routine Practices and Additional Precautions - Routine Practices - IPC-B-10" last revised in December of 2014, which stated that hand hygiene was to be performed at the point of care, and that all staff would perform hand hygiene before, between and after activities that may result in cross contamination. The policy identified that staff would follow the four moments of hand hygiene.

During an interview with the DOC, they confirmed that the home implemented the policy “Routine Practices and Additional Precautions - Routine Practices - IPC-B-10" and that the staff were required to follow the four moments of hand hygiene. [s. 229. (4)]

2. During a tour of the home on a specific date during the inspection, Inspector #625 observed the following on a resident home area:
- a specific resident's bedroom had personal protective equipment (PPE) hanging on the door without signage indicating that additional precautions were required or what type of precautions were required;
- a second resident's bedroom had PPE hanging from the door without signage indicating that additional precautions were required or what type of precautions were required; and
- a third resident's bedroom had a specific precautions sign on the door but no PPE present.

On a second specific date during the inspection in November of 2016 at 1037 hours, Inspector #625 observed:
- a specific resident's bedroom continued to have PPE hanging on the door without signage indicating that additional precautions were in place;
- a second resident's bedroom continued to have PPE hanging on the door without signage indicating that additional precautions were in place; and
- a third resident's bedroom continued to have specific precautions signage posted with no PPE present.

During the observation of the identified resident rooms on a day in November of 2016, Inspector #625 interviewed Housekeeping Aide #114 regarding one specific resident room having PPE hanging on the doorway without signage indicating that additional precautions were in place. The Housekeeping Aide stated that if there was PPE on the door without signage present, they would check the unit whiteboard to find out what the resident had tested positive for.

On a day in November of 2016, Inspector #625 reviewed the whiteboard on the resident home area and noted that one specific resident had a particular medical diagnosis, that a second resident had a particular medical diagnosis and that a third resident was not listed on the whiteboard.

During an interview with Inspector #625 on a day in November of 2016, RPN #107 identified that the home normally did not put up contact precautions signage for residents if precautions were long-term. The RPN stated that the home's staff would ask the registered nursing staff what type of precaution to take and, if they didn't know, they would fully immerse themselves in PPE.

On a day in November of 2016, Inspector #625 and the DOC attended a resident home area. The DOC acknowledged that two specific residents did not have specific precautions signage posted, but required signage. The DOC then spoke to RPN #107 in the presence of Inspector #625. RPN #107 stated that a third resident no longer had a particular medical diagnosis and did not require PPE or signage, and that the precautions sign currently posted was not required. The DOC attended the third resident's room and removed their precautions sign. During a second interview with Inspector #625 on the same date, the DOC stated that they had discovered that staff had incorrectly resolved a component of the care plan for the third resident due to an error in responding to diagnostic test results. The DOC stated that the care plan related to a particular medical diagnosis would be re-initiated, the PPE and signage would be placed on the resident's door, and the resident's name would be added to the resident home area's whiteboard.

On a day in November of 2016, Inspector #625 reviewed the third resident's health care record related to the resident's particular medical diagnosis. The Inspector reviewed:
- a LTC ARO Guidelines Screening & Surveillance Algorithm which indicated the test results for the resident for a particular diagnostic test from two specific locations on their body on a date in the spring of 2015; from one specific location on their body on a date in the winter of 2015; from two specific locations on their body on a date in the winter of 2015; and from one particular location on their body on a date in the winter of 2016; and

- laboratory reports related to the resident's particular medical diagnosis dated during the spring of 2016 and winter of 2015, which supported the testing sites and results related to the particular medical diagnosis for the resident for the tests completed.

Inspector #625 reviewed the home's policy titled "Infection Control – Multi-Drug Resistant Organisms: MRSA and VRE – RC-I-120" dated September 2009, which indicated that residents identified with MRSA would have signage inside their room to inform care providers or visitors of the additional precautions and to instruct visitors to see the Charge Nurse.

Inspector #625 reviewed the policy's associated "LTC ARO Guidelines VRE/MRSA Screening & Surveillance Algorithm" (undated) that identified MRSA screening sites as: the initial positive site (always), nares (always), groins (always) and open wounds.

Inspector #625 reviewed the home's policy titled "Antibiotic Resistant Organisms – Extended-Spectrum Beta-Lactamase-Producing Bacteria (ESBL) Surveillance – Ontario – IPC-D-10-ON" last revised May 2014, which indicated that staff were to initiate additional precautions.

Inspector #625 reviewed the home's policy titled "Additional Precautions – Contact Precautions – IPC-B-20" last revised August 2015, which identified that staff were to use contact precautions, in addition to routine precautions, to reduce the risk of transmitting infectious agents via contact with an infectious person, and that staff were to place contact precautions signage at the entrances of resident room or in other visible locations.

In summary, the home's staff failed to participate in the implementation of the home's infection prevention and control program by failing to follow the home's policies related to the posting of signage for additional precautions and the application of associated PPE, and by failing to follow the home's procedure related to surveillance and testing for a particular medical diagnosis. [s. 229. (4)]

3. The licensee has failed to ensure that on every shift, the symptoms of infection were recorded and immediate action was taken as required.

During stage one of the inspection, it was identified through a Minimum Data Set (MDS) assessment that resident #018 had a particular previously acquired medical condition .

Inspector #196 reviewed the health care records of resident #018. The "Resident Home Area Daily Infection Control Surveillance" form identified a particular medical diagnosis with no recorded date of onset. The physician's orders dated during the summer of 2016, included a diagnostic test to rule out a particular medical diagnosis, an order for a treatment and noted a particular medical diagnosis. The diagnostic test result identified a particular medical diagnosis. The progress notes dated one specific date during the summer of 2016 to a second specific date 11 days afterwards, when the treatment was completed, did not include the recording of symptoms of infection on every shift.

On a day in November of 2016, Inspector #196 conducted an interview with the DOC regarding the recording of symptoms of infection of resident #018 on every shift. The DOC reviewed the progress notes and confirmed that, on a date during the summer of 2016, there were no assessments of infection documented for any of the shifts. In addition, the DOC identified that there was no documentation of the symptoms of infection during all three shifts on one date during the summer of 2016; during the night and evening shifts on another date during the summer of 2016; during all three shifts on three dates during the summer of 2016; during the night shift on one date during the summer of 2016; during all three shifts on two dates during the summer of 2016; and during the night and day shifts on three dates during the summer of 2016.

Inspector #196 conducted an interview with staff member RN #111 on a day in November of 2016. The RN reported that signs and symptoms of infection were to be documented in the resident's progress notes, on every shift, if an active infection was present. [s. 229. (5) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with 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. (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 has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During stage one of the inspection, on a day in November of 2016, Inspector #625 interviewed resident #012's family member, family member #115, about the home's accommodation of the resident's preferences on how they were dressed. Family member #115 stated that they had requested that resident #012 be dressed in a particular manner but that the request was not always followed, despite notification in writing detailing this request. Family member #115 stated that the notification had been in place since the resident's admission. The family member stated that resident #012 had not been dressed in the manner they had requested when they arrived on a day in November of 2016, and that the family member dressed the resident in the manner that they had requested.

On a day in November of 2016, Inspector #625 reviewed an undated written notice that requested staff dress the resident in a specific manner. The notice also stated the reason for dressing the resident in the manner requested and the outcome of dressing the resident in the requested manner.

Inspector #625 reviewed resident #012's care plan in place on a date in November of 2016. The care plan identified that the resident was admitted to the home on a specific date in 2014, and required the assistance of staff to dress. The care plan did not identify that staff were to dress the resident in the manner requested by the resident's family member.

On a day in November of 2016, Inspector #625 interviewed resident #012's care giver #116, who stated that they had arrived that date and found resident #012 not dressed in the manner requested by the family member and that the resident had demonstrated a certain characteristic by not being dressed in the manner requested by the family member. The care giver stated that the resident was often not dressed in the manner requested by the family member.

During an interview with Inspector #625 on a day in November of 2016, RPN #117 stated that they were familiar with the notice for resident #012 that identified that family member #115 wanted the resident dressed in a specific manner. The RPN reviewed the resident's current care plan and acknowledged that it did not contain any reference to the resident being dressed in the manner requested by the family member. The RPN also stated that, if it was family member #115's preference and the resident liked it, it should have been listed in the care plan for staff to follow.

During an interview with Inspector #625 on a day in November of 2016, PSW #110 stated that they were aware of the notice requesting resident #012 be dressed in the particular manner. The PSW reviewed the resident's current care plan and acknowledged that it did not mention the preference for the resident being dressed in the particular manner, but should have.

During an interview with Inspector #625 on a day in November of 2016, the Executive Director (ED) stated that the information from the notice related to family member #115's preferences for dressing resident #012 should have been included in the resident's care plan. [s. 6. (2)]

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

During stage one of the inspection, it was identified through an MDS assessment that resident #003 had a specific criteria related to continence.

On a day in November of 2016, Inspector #196 reviewed the health care records for resident #003. The current care plan identified, under the focus of toileting, that the resident required the assistance staff with a particular aspect of toileting.

On a day in November of 2016, Inspector #196 conducted an interview with resident #003 who reported that they were independent with the particular aspect of toileting.

On a day in November of 2016, Inspector #196 conducted an interview with PSW #108 and RPN #107, who both reported that resident #003 was independent with the particular aspect of toileting and did not require the assistance of staff. [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 to 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 requires the licensee to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective

drug therapy outcomes for residents, s. 114 (1). The Regulation also requires the licensee to ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, s. 114 (2).

On a day in November of 2016, Inspector #625 observed resident #021 in a resident home area dining room with their morning medications in a medicine cup. The Inspector noted that there were no staff watching the resident. The resident then dropped a medication tablet and asked the Inspector to pick it up for them. The Inspector observed that RPN #104 was in the medication room, proceeded to exit the medication room and headed away from the dining room.

On that same day in November of 2016, Inspector #625 interviewed RPN #104 who stated that the resident was not supposed to be left alone with their pills, but that the Executive Director had pulled the RPN away to speak with them, preventing the RPN from observing resident #021 take their pills.

On November 9, 2016, Inspector #612 reviewed the home's policy titled "Medication Pass - Procedure - 04-02-20" last reviewed June 23, 2014, which stated that the nurse would administer medications to the resident ensuring that oral medications had been swallowed and would not leave medications with the resident.

During an interview with Inspector #612 on a day in November of 2016, the DOC confirmed that registered staff were not to leave medications unattended with a resident, and were to ensure that the residents had taken all of their medications. [s. 8. (1) (b)]

2. Ontario Regulation 79/10 s. 68 (2)(e)(i) requires every licensee of a long-term care home to ensure that the nutrition care and hydration programs included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter.

On two days in November of 2016, during the stage one staff interview and census review, it was identified that monthly weights had not been entered into the Point Click Care (PCC) electronic health care record for resident #022 for two consecutive months in 2016. The stage one census review also identified that the resident had been admitted on a specific date during the summer of 2016, and, since the resident's admission, only one monthly weight had been entered into PCC for the resident.

During an interview with Inspector #625 on a day in November of 2016, RPN #104 identified that monthly weights for resident #022 for two consecutive months during 2016 had not been entered into PCC. The RPN stated that PSWs were to take and record resident weights on the "Weights and Vitals Batch Entry" worksheets and that RPNs were to document the values into PCC. RPN #104 reviewed a resident home area's "Weights and Vitals Batch Entry" worksheet for a particular month in 2016 for resident #022. The RPN stated that one particular month's weight was blank and that another particular month's hand written weight was incorrect, which was why it had not been entered into PCC, and should have been redone at the time it was noted to be incorrect.

Inspector #625 reviewed a resident home area's "Weights and Vitals Batch Entry" worksheet for a particular month in 2016 and noted that resident #022 had weighed a specific weight in one particular month in 2016, did not have weight listed for the following month, and had a handwritten weight of greater than 40 kgs more than the specific weight taken two month's prior. The Inspector also reviewed the "[resident home area] Wheelchair Weights" sheet updated in April of 2016, which identified that resident #022's ambulation equipment weighed a specific amount. When the Inspector compared the weight entered into PCC in one month in 2016 and the hand written weight on the "Weights and Vitals Batch Entry" worksheet for a month two months from the first weight, the two weights reflected that the resident had gained in excess of 40 kgs over a two month period.

Inspector #625 reviewed the home's policy titled "Weight and Height Monitoring – CARE7-010.03" effective August 31, 2016, which identified that residents were to be weighed and that the weight was to be documented by the seventh day of each month. The policy also identified that a weight loss or gain of 2.0 kg or greater from the preceding month would be immediately confirmed.

During an interview with Inspector #625 on a day in November of 2016, the DOC stated that the home had a monthly weight monitoring system in place but that it was not being implemented as expected with respect to missing and erroneous weights identified in two specific months in 2016. [s. 8. (1) (b)]

3. During the stage one census review, monthly weighs had not been entered into the PCC electronic health care record for resident #012 for two consecutive months in 2016.

During an interview with Inspector #625 on a day in November 2016, RPN #104 identified that monthly weights for resident #012 for the two consecutive months in 2016

had not been entered into PCC. RPN #104 reviewed the unit's "Weights and Vitals Batch Entry" worksheet for one particular month in 2016 for resident #012 and stated that the previous month's weight was blank and that the particular month's hand written weight was listed as a specific value, but had not been entered into PCC as it should have been.

Inspector #625 reviewed the resident home area's "Weights and Vitals Batch Entry" worksheet for a particular month in 2016 and noted that resident #012 did not have a weight listed for the month prior to the particular month in 2016, and had a handwritten weight listed of a specific amount for the particular month of a specific amount. [s. 8. (1) (b)]

4. During the stage one census review, a monthly weigh had not been entered into the PCC electronic health care record for resident #021 for a particular month in 2016.

During an interview with Inspector #625 on a day in November of 2016, RPN #104 identified that a monthly weight for resident #021 for a particular month in 2016 had not been entered into PCC. RPN #104 reviewed the unit's "Weights and Vitals Batch Entry" worksheet for the particular month in 2016 for resident #021 and stated that the particular month's hand written weight was incorrect, which was why it had not been entered into PCC, and should have been redone at the time it was noted to be incorrect.

Inspector #625 reviewed the resident home area's "Weights and Vitals Batch Entry" worksheet for that particular month in 2016 and noted that resident #021 had a handwritten weight listed of a specific amount for that particular month. The Inspector also reviewed the "[resident home area] Wheelchair Weights" sheet updated in April of 2016, which identified that resident #021's mobility aide weighed a specific amount. When the Inspector compared the weight entered into PCC in the month prior to the particular month and the hand written weight on the "Weights and Vitals Batch Entry" worksheet for the particular month, the two weights reflected that the resident had gained in excess of 20 kg over a one month period. When the Inspector deducted the weight of the resident's mobility aide, the weights reflected that the resident had gained in excess of five kgs over a one month period. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, specifically related to the home's policies titled "Medication Pass - Procedure - 04-02-20" last reviewed June 23, 2014, and "Weight and Height Monitoring – CARE7-010.03" effective August 31, 2016, to be implemented voluntarily.

WN #5: 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 has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

Inspector #612 reviewed a Critical Incident System report submitted by the home to the Director on a specific date in the summer of 2016, related to an incident that occurred the same day. The report stated that resident #004 was being transferred using mobility aide made from polyvinyl chloride (PVC). The mobility aide got caught on a depression on the floor. When the PSW pushed the resident over the depression, the chair broke and the resident was injured.

The Inspector reviewed the home's investigation documents, which included a picture of the floor indicating that there was a gap between a plumbing fixture and the flooring, approximately one and a half centimeters. After this incident, three additional mobility aides were removed and tagged out for the maintenance department to review and repair.

The Inspector interviewed the DOC who stated that this incident was likely a result of a combination of the poor integrity of the mobility aide, the gap between the plumbing fixture and the flooring, and the lip on the floor. The DOC confirmed that there was no one monitoring the integrity of the mobility aides, and that they were unsure how old they were.

The Inspector interviewed the Environmental Services Manager (ESM) who stated that they did not believe the plumbing fixture was the problem, and stated it was likely due to the integrity of the mobility aide. They stated that the maintenance department did not monitor the mobility aides and relied on the front line staff to report any issues or concerns with them. The ESM stated that new tile flooring had been installed a few weeks prior to the incident, sometime between the end of July and the beginning of August, which resulted in the one and a half centimeter gap between the flooring and the plumbing fixture. The gap was not noticed until the ESM inspected the flooring after the incident. [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 to ensure that ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

During a tour of the home on a day during the inspection, Inspector #625 observed that, in a resident home area spa/bathing room, the call bell wall unit on a wall adjacent to the window was not attached to the green call bell cord. The Inspector attached the call bell

cord and pulled it. When the cord was pulled, it detached from the call bell wall unit prior to exerting enough force to sound the call bell. On another resident home area, in a washroom, spa/bathing room, and shower/washroom, when the call bell cords were pulled, they detached from the call bell wall units prior to exerting enough force to sound the call bells.

On the same day during the inspection, the ESM approached Inspectors #196, #612 and #625. The EMS stated that an audit of the call bells had been completed six weeks prior and some call bell cords had been replaced. They further stated that the building was eleven years old and the call bell cords were "bound to go", and that the only way they could be guaranteed to function was if all of the call bell cords were changed at one time.

During stage one of the inspection, residents #001, #020 and #022 were noted to have call bell cords in their washrooms that would detach from the call bell wall units when pulled, prior to the cord exerting enough force to engage the call bell, resulting in the call bells not sounding.

On a day in November of 2016, Inspector #612 interviewed the ESM who stated that the call bell cords detached from the wall alarm units as a quick release mechanism to prevent a resident from using the cord to choke themselves, for safety reasons. They stated that when the call bell cord was pulled and it detached from the call bell wall unit [prematurely], the call bell would not sound. The ESM stated that when the staff notified them that the cord had come apart from the wall unit component [prematurely], they would replace the cord with a new one, as required. [s. 17. (1) (a)]

2. During stage one of the inspection, on a specific day at 1406 hours, Inspector #625 observed resident #023's call bell cord wound in a circular fashion underneath the resident's bed with the call bell inaccessible to the resident. On another day during the inspection at 1620 hours, the Inspector again observed resident #023's call bell stored under the resident's bed in the same manner that it had been observed the previous day.

On a day in November of 2016, Inspector #625 observed resident #023 laying in their bed with the call bell on the floor near the head board, inaccessible to the resident.

On another day in November of 2016, Inspector #625 observed resident #023 in their room with their call bell laying on the floor beside and underneath resident #023's bed. The end of the call bell containing the button to depress to call for assistance was underneath the bed frame in an area that was difficult to access.

During an interview with Inspector #625 on a day in November of 2016, PSW #110 stated that the resident's call bell may have fallen onto the floor as the resident should have access to the call bell.

A review by Inspector #625 of resident #023's current care plan on November 10, 2016, identified interventions under the focus of risk for falls which included keeping resident #023's call bell cord within reach.

A review by Inspector #625 of the home's procedure titled "Communication and Response (Call Bell) System" (no index number) effective August 31, 2016, identified that call bells were to be easily seen, accessed and used by residents, staff and visitors at all times.

During an interview with Inspector #625 on a day in November of 2016, the ED stated that all residents should have access to their call bells unless otherwise specified in their care plans. [s. 17. (1) (a)]

3. On a day in November of 2016, at 0933 hours, resident #008 called out for assistance from their room to Inspector #625 who had exited a neighbouring room. The Inspector entered the resident's room and observed the resident's call bell inaccessible to the resident as it was wrapped around the resident's bed rail, while the resident was seated with their back towards their bed with approximately 45 centimeters in between the resident and their bed. The resident requested the call bell to call staff for assistance with toileting.

During an interview with Inspector #625 on a day in November of 2016, PSW #112 stated that call bells were supposed to be within the reach of residents at all times and that PSW #112 had informed the staff person providing care to resident #008 about this requirement.

A review by Inspector #625 of resident #008's current care plan on November 10, 2016, identified interventions under the focus of risk for falls and toileting which included keeping resident 008's call bell cord within reach. [s. 17. (1) (a)]

4. On a day in November of 2016, at 1047 hours, Inspector #625 observed resident #024 calling for assistance from behind the closed door to their room. The Inspector opened the resident's door and observed the resident's call bell attached to the bed rail while the

resident was seated angled away from their bed, and was unable to reach the call bell.

During an interview with Inspector #625 on a day in November of 2016, PSW #113 stated that resident #024 would use the call bell when it was attached to the bed rail to sound it. The PSW identified that resident #024 was not able to reach their call bell from the location they were observed at.

A review by Inspector #625 of resident #024's current care plan on November 10, 2016, identified interventions under the focus of risk for falls which included keeping resident #024's call bell within reach at all times. [s. 17. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #012 was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variation in resident functioning at different times of the day.

A Critical Incident System (CIS) report was submitted by the home to the Director on a particular date in the fall of 2016, for an incident that was identified as improper or incompetent treatment of a resident that resulted in harm or risk of harm to the resident. The report indicated that resident #012 had exhibited a responsive behaviours and that two PSWs used force during the provision of care. The report specifically identified that PSW #118 applied force to resident #012 during the care and that an injury to the resident was later noted.

During a review of the home's investigation file into the incident, Inspector #625 reviewed notes from an interview with PSW #118. The notes indicated the PSW had stated that PSW #119 had requested the assistance of PSW #118 with resident #012's care. The notes indicated that that resident #012's care was partially completed when the resident exhibited responsive behaviours. The notes also identified that PSW #118 stated they applied specific force to the resident for the safety of the PSWs and the resident.

Inspector #625 also reviewed notes from an interview with PSW #119. The notes indicated that the PSW stated that resident #012 either exhibited the responsive behaviours or did not, and that the PSW attempted to use other approaches to provide care to the resident. The notes identified that PSW #119 had approached resident #012 and asked PSW #118 to assist with the care of resident #012. PSW #119 stated that PSW #118 had applied force to resident #012 to prevent possible injury to the staff and the resident, and that the PSWs then left the resident.

Inspector #625 reviewed resident #012's care plan in place on November 3, 2016, and was not able to locate interventions related to resident #012's specific responsive behaviours.

During an interview with Inspector #625 on a day in November of 2016, PSW #110 stated that resident #012 would, at times, exhibit responsive behaviours resulting in staff ceasing care when that occurred. The PSW stated that the responsive behaviours should be included in the resident's care plan but was not able to locate any reference related to resident #012's specific responsive behaviours.

During an interview with Inspector #625 on a day in November of 2016, RPN #120 stated that interventions related to resident #012's specific responsive behaviours should have been in the resident's care plan, and that the care plan focus identifying responsive behaviours did not have corresponding interventions for all of the behaviours listed.

During an interview with Inspector #625 on a day in November of 2016, RPN #121 stated that the resident could exhibit responsive behaivours with care.

During an interview with Inspector #625 on a day in November of 2016, RAI Coordinator #106 stated that they had updated the resident's care plan to include specific interventions related to responsive behaviours.

Inspector #625 reviewed resident #012's care plan in place on November 10, 2016, and noted that, under the foci of responsive behaviours and one particular aspect of care, there continued to be no identification of the specific responsive behaviours related to the particular aspect of care.

During a phone interview with Inspector #625 on a day in November of 2016, the ED reviewed the resident's care plan dated a specific date in the winter of 2016, which was in place at the time of the incident. The ED stated that they were not able to locate any reference to resident #012's specific care needs and associated responsive behaviours. [s. 26. (3) 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 to ensure that a plan of care for resident #012 is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

During stage one of the inspection, it was identified through an MDS assessment that resident #011 exhibited a characteristic related to continence.

A review of resident #011's current care plan by Inspector #625 on November 7, 2016, identified that the resident required support related to continence.

During a review of resident's #011s health care record by Inspector #625, a continence assessment could not be located for the resident that met the requirements detailed in Ontario Regulation 79/10 r. 51 (2)(a).

During an interview with Inspector #625 on a day in November of 2016, RN #111 stated that the home did not use a continence assessment to assess residents' continence characteristics including those identified in r. 51(2)(a) but that the home used a "First Quality 3 Day Continence Diary".

During interviews with Inspector #625 on a day in November of 2016, the DOC stated that the home used several documents related to continence for residents including a "Resident Admission Assessment/Plan of Care", a "Resident Admission Checklist" and a "First Quality 3 Day Continence Diary". The DOC stated that the home had not

conducted a continence assessment for resident #011 which identified causal factors, type of incontinence and which was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence, where the condition or circumstances of the resident required. The DOC stated that the home did not use a continence assessment that met the requirements outlined in Ontario Regulation 79/10 r. 51(2)(a). [s. 51. (2) (a)]

2. During stage one of the inspection, it was identified through an MDS assessment that resident #003 exhibited a characteristic related to continence.

A review of resident #003's current care plan by Inspector #196 identified that the resident required support related to their continence.

During a review of resident #003's health care record by Inspector #196, an electronic continence assessment could not be located that assessed the resident's incontinence.

On November 9, 2016, Inspector #196 conducted an interview with the DOC who reported that there was no assessment tool used for the assessment of the continence status of residents, other than the "First Quality 3 Day Continence Diary". [s. 51. (2) (a)]

3. During stage one of the inspection, it was identified through an MDS assessment that resident #006 exhibited a characteristic related to continence.

A review of resident #006's current care plan by Inspector #196 identified that the resident required support related to their continence.

During a review of resident #006's health care record by Inspector #196, an electronic continence assessment could not be located that assessed the resident's incontinence. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

Issued on this 11th day of January, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KATHERINE BARCA (625), LAUREN TENHUNEN (196), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2016_433625_0018
Log No. / Registre no:	022121-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 13, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	PINEWOOD COURT 2625 WALSH STREET EAST, THUNDER BAY, ON, P7E-2E5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee shall ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

The licensee must:
(a) Conduct regular audits of the resident home areas to monitor the offering and provision of a beverage to all residents, with an emphasis on a between-meal beverage in the morning;
(b) Ensure that the home's management team participates in conducting the audits; and
(c) Maintain records of the audits which include the dates of the audits, the times the audits were conducted, observations related to the provision or lack of provision of a beverage to the residents, any corrective actions taken to address deficiencies, and the person(s) completing the audits.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During stage one of the inspection, on a day in November of 2016, resident #003, #005 and #006 stated to Inspector #196 that they were not offered a beverage between breakfast and lunch.

On another day in November of 2016, Inspector #612 observed a resident home area between 0930 hours and 1115 hours and noted that no beverage was offered to the residents on the home area.

On the same day in November of 2016, Inspector #196 observed a second resident home area between 0930 hours and 1100 hours and noted that no beverage was offered to the residents on the home area.

On another day in November of 2016, Inspector #612 observed a third resident home area between 0915 hours and 1100 hours and noted that no beverage was offered to the residents on the home area.

On a day in November of 2016, Inspector #612 interviewed Personal Support Worker (PSW) #109 and PSW #110 who stated that they were expected to offer a beverage to residents between breakfast and lunch, however they often did not have time as they were providing other care to residents. They stated that if a resident requested a beverage they would provide something to drink. PSW #109 stated if a beverage was not offered between breakfast and lunch, they would document it as not applicable in Point of Care (POC) under the per cent of snack eaten between meals.

On a day in November of 2016, Inspector #612 reviewed the documentation in POC for seven days in November of 2016, for residents #003, #005 and #006. For resident #003, the provision of a beverage between breakfast and lunch was documented as not applicable for six of the seven days, and for one day there was nothing documented. For resident #005, it was documented as not applicable for five of the seven days and on one day nothing was documented. For resident #006, six of the last seven days were documented as not applicable, and on one day nothing was documented.

The Inspector reviewed the home's policy titled "Nourishments, Supplements, and Prescribed Items" (no index number) effective August 31, 2016, which stated that a between meal nourishment would be provided as outlined in the snack menu. The policy also stated that the nourishment/snack menu cycle and delivery times were developed according to provincial regulations and Residents' Council feedback and suggestions.

On a day in November of 2016, Inspector #612 interviewed the Director of Care (DOC) who stated that staff were expected to offer the residents a beverage in

the morning, between breakfast and lunch.

Non-compliance has been previously identified during Resident Quality Inspection #2015_246196_0016 conducted on November 16, 2015, and during Complaint inspection #2016_512196_0013 conducted on August 15, 2016, when voluntary plans of correction were issued.

The decision to issue this compliance order was based on the scope which was observed to have occurred on three out of four resident home areas, the severity which indicated there was the potential for actual harm to occur, and the compliance history which, despite being previously identified as non-compliant twice, the home continues to demonstrate non-compliance in this area of the legislation. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 ensure that all staff participate in the implementation of the infection prevention and control program.

The licensee is ordered, with respect to hand hygiene, to:
(a) Conduct routine audits of the resident home areas to ensure that the home's hand hygiene program is being implemented by the staff, with an emphasis on meal service and medication administration times;
(b) Ensure that the home's management team participates in conducting the audits; and
(c) Maintain records of the audits which include the dates of the audits, the times the audits were conducted, observations made, corrective action taken, and the person(s) completing the audits.

The home is ordered, with respect to antibiotic-resistant organisms (AROs), to:
(a) Identify residents in the home who have tested positive for an ARO within the last year (365 days);
(b) Audit the health care records of the resident to ensure that the surveillance and testing of the status of the residents with respect to AROs has been conducted as per the home's policies and algorithms. Should the home identify that the surveillance and testing were not completed as per the home's policies and algorithms, the home shall rectify the deficiencies;
(c) Ensure that the home's policies and algorithms have been followed with respect to the use of signage, the application of personal protective equipment and the practices of the home's staff in providing care to the residents;
(d) Maintain records of the audits which include the dates of the audits, the times the audits were conducted, findings, corrective actions taken and the name(s) of the person(s) conducting the audits; and
(e) Develop an ongoing monitoring and tracking system to ensure that the home's policies and algorithms related to AROs are being followed.

Grounds / Motifs :

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

During a tour of the home on a specific date during the inspection, Inspector #625 observed the following on a resident home area:
- a specific resident's bedroom had personal protective equipment (PPE) hanging on the door without signage indicating that additional precautions were required or what type of precautions were required;

- a second resident's bedroom had PPE hanging from the door without signage indicating that additional precautions were required or what type of precautions were required; and
- a third resident's bedroom had a specific precautions sign on the door but no PPE present.

On a second specific date during the inspection in November of 2016 at 1037 hours, Inspector #625 observed:
- a specific resident's bedroom continued to have PPE hanging on the door without signage indicating that additional precautions were in place;
- a second resident's bedroom continued to have PPE hanging on the door without signage indicating that additional precautions were in place; and
- a third resident's bedroom continued to have specific precautions signage posted with no PPE present.

During the observation of the identified resident rooms on a day in November of 2016, Inspector #625 interviewed Housekeeping Aide #114 regarding one specific resident room having PPE hanging on the doorway without signage indicating that additional precautions were in place. The Housekeeping Aide stated that if there was PPE on the door without signage present, they would check the unit whiteboard to find out what the resident had tested positive for.

On a day in November of 2016, Inspector #625 reviewed the whiteboard on the resident home area and noted that one specific resident had a particular medical diagnosis, that a second resident had a particular medical diagnosis and that a third resident was not listed on the whiteboard.

During an interview with Inspector #625 on a day in November of 2016, RPN #107 identified that the home normally did not put up contact precautions signage for residents if precautions were long-term. The RPN stated that the home's staff would ask the registered nursing staff what type of precaution to take and, if they didn't know, they would fully immerse themselves in PPE.

On a day in November of 2016, Inspector #625 and the DOC attended a resident home area. The DOC acknowledged that two specific residents did not have specific precautions signage posted, but required signage. The DOC then spoke to RPN #107 in the presence of Inspector #625. RPN #107 stated that a third resident no longer had a particular medical diagnosis and did not require PPE or signage, and that the precautions sign currently posted was not required.

The DOC attended the third resident's room and removed their precautions sign. During a second interview with Inspector #625 on the same date, the DOC stated that they had discovered that staff had incorrectly resolved a component of the care plan for the third resident due to an error in responding to diagnostic test results. The DOC stated that the care plan related to a particular medical diagnosis would be re-initiated, the PPE and signage would be placed on the resident's door, and the resident's name would be added to the resident home area's whiteboard.

On a day in November of 2016, Inspector #625 reviewed the third resident's health care record related to the resident's particular medical diagnosis. The Inspector reviewed:
- a LTC ARO Guidelines Screening & Surveillance Algorithm which indicated the test results for the resident for a particular diagnostic test from two specific locations on their body on a date in the spring of 2015; from one specific location on their body on a date in the winter of 2015; from two specific locations on their body on a date in the winter of 2015; and from one particular location on their body on a date in the winter of 2016; and
- laboratory reports related to the resident's particular medical diagnosis dated during the spring of 2016 and winter of 2015, which supported the testing sites and results related to the particular medical diagnosis for the resident for the tests completed.

Inspector #625 reviewed the home's policy titled "Infection Control – Multi-Drug Resistant Organisms: MRSA and VRE – RC-I-120" dated September 2009, which indicated that residents identified with MRSA would have signage inside their room to inform care providers or visitors of the additional precautions and to instruct visitors to see the Charge Nurse.

Inspector #625 reviewed the policy's associated "LTC ARO Guidelines VRE/MRSA Screening & Surveillance Algorithm" (undated) that identified MRSA screening sites as: the initial positive site (always), nares (always), groins (always) and open wounds.

Inspector #625 reviewed the home's policy titled "Antibiotic Resistant Organisms – Extended-Spectrum Beta-Lactamase-Producing Bacteria (ESBL) Surveillance – Ontario – IPC-D-10-ON" last revised May 2014, which indicated that staff were to initiate additional precautions.

Inspector #625 reviewed the home's policy titled "Additional Precautions – Contact Precautions – IPC-B-20" last revised August 2015, which identified that staff were to use contact precautions, in addition to routine precautions, to reduce the risk of transmitting infectious agents via contact with an infectious person, and that staff were to place contact precautions signage at the entrances of resident room or in other visible locations.

In summary, the home's staff failed to participate in the implementation of the home's infection prevention and control program by failing to follow the home's policies related to the posting of signage for additional precautions and the application of associated PPE, and by failing to follow the home's procedure related to surveillance and testing for a particular medical diagnosis.
(625)

2. On a day in November of 2016, Inspector #612 observed the dining service on a resident home area. The Inspector observed two of the PSWs serve clean plates to one resident, remove two dirty plates and then proceed to assist residents with eating, without washing their hands.

During the same dining service, the Inspector observed Registered Practical Nurse (RPN) #104 administer medications to four residents without washing their hands in-between the medication administration to the residents. The RPN then served a sandwich to a resident before returning to their medication cart to administer medications to another resident. The RPN touched residents' utensils and beverage cups in between administering the medications.

On another day in November of 2016, Inspector #612 observed RPN #107 on a second resident home area. The RPN assisted a resident with their mobility aid and then prepared medications and administered them to the resident, without washing their hands. The RPN then sat next to another resident, rubbed their shoulder, and administered their medication without washing their hands. As they were returning to the medication cart, RPN #107 moved a resident's mobility aid, approached another resident and rubbed their back, and then washed their hands.

The Inspector reviewed the home's policy titled "Routine Practices and Additional Precautions - Routine Practices - IPC-B-10" last revised in December of 2014, which stated that hand hygiene was to be performed at the point of care, and that all staff would perform hand hygiene before, between and after

activities that may result in cross contamination. The policy identified that staff would follow the four moments of hand hygiene.

During an interview with the DOC, they confirmed that the home implemented the policy "Routine Practices and Additional Precautions - Routine Practices - IPC-B-10" and that the staff were required to follow the four moments of hand hygiene.

Non-compliance has been previously identified during Resident Quality Inspection #2015_246196_0016 conducted on November 16, 2015, and during Resident Quality Inspection #2014_246196_0017 conducted on September 21, 2014, when two voluntary plans of correction were issued.

The decision to issue this compliance order was based on the scope which demonstrated a pattern of deficient practice, the severity which indicated there was a potential for harm to occur, and the compliance history which, despite the home being previously identified as non-compliant twice, non-compliance continues in this area of the legislation. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 13th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Katherine Barca

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