Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 29, 2013	2013_229213_0053	L-000907-13	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

McGARRELL PLACE
355 McGarrell Drive, LONDON, ON, N6G-0B1

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

RHONDA KUKOLY (213), CARMEN PRIESTER (203), CAROLEE MILLINER (144), TAMMY SZYMANOWSKI (165)

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): November 12, 13, 14, 15, 19, 2013

Critical incident #2964-000018-13 was inspected concurrently within this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Associate Director of Care/RAI (Resident Assessment Instrument) Coordinator, Environmental Services Manager, Food Services Manager, Program Director, Resident Services Coordinator, Dietary Aides, Cook, Quality Improvement Manager, Education Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Staff, Residents and Family members of Residents

During the course of the inspection, the inspector(s) toured the home, observed meal service, medication passes, medication storage areas and care provided to residents, reviewed medical records and plans of care for identified residents, reviewed policies and procedures of the home, and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

Infection Prevention and Control

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Quality Improvement

Reporting and Complaints

Residents' Council

Skin and Wound Care

Training and Orientation

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the persons who have received training under section (2) receive retraining in the areas mentioned in that subsection at times or intervals provided for in the regulations as evidenced by:
1. Documentation regarding training reveals the following percentages of staff participated in each type of training in the year 2013:
Resident Bill of Rights: 37%
Prevention of Abuse Training: 35%
Mandatory Reporting: not listed as part of their education program.
Whistle Blower protection: not listed as part of the Education Program
Minimizing of Restraints: 8%
Fire Prevention and safety: 43%
Evacuation Procedures: 37%
Concern/complaint Management: 43%
Safe use of Equipment: 0%
Cleaning and Sanitization of Equipment: 47%
This was verified by the Education Coordinator.

2. Documentation regarding training reveals the following percentages of staff participated in each type of training in the year 2012:
Prevention of Abuse : 35%
Resident Rights: 37%
Falls:0%
Restraint Use: 0%
Infection Control:
Just Clean Your Hands: 3%
Outbreak Management:1%
Pain: 5%
Palliative: 15%
Safe and Correct Use of Equipment: 0%
Cleaning and Disinfecting: 2%
Modes of transmission: 4%
Heat Risk: 0%
Continence:39%
Responsive Behavior:19%
This was verified by the Education Coordinator.

3. Four out of nine staff interviewed (including 6 PSWs, 1 dietary aid, 1 RPN and 1

housekeeping staff) did not recall having training or education in the prevention of abuse in the last year. [s. 76. (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 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 did not ensure that 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, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with as evidenced by:
a) The home's policy #LP-B-20 Management of Concerns/Complaints/Compliments indicates: "Formal Written Complaints #12. Upon receipt of a formal letter of complaint or concern (either in hard copy or in electronic format), the Executive Director/designate will initiate an investigation and follow applicable provincial or jurisdictional reporting requirements".
b) The Executive Director and the Director of Care confirmed that they received a complaint via email related to a Resident and did not report this complaint to the director and therefore did not follow the home's policy related to Management of Concerns/Complaints/Compliments. [s. 8. (1) (b)]

2. The licensee did not ensure that 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, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with as evidenced by:
a) The home's policy #LP-B-20 Management of Concerns/Complaints/Compliments indicates: Verbal Concerns/Complaints "#7. The individual who is first aware of a concern will initiate the Client Service Response form (CSR). A copy of the form as it is initially completed will be forwarded to the Executive Director. The original form will be forwarded to the member of the team who will be responsible for the resolution of the concern. #9. The concern will be responded to within 24-48 hours (2 business days). The person who raised the initial concern will be informed of the actions being taken to resolve the concern. #10. The CSR form will be completed in full and all actions taken during the investigation will be documented. #11. Upon completion of the investigation of the concerns, a response will be provided to indicate what has been done to resolve the complaint, or, if the complaint is found to be unfounded, an explanation will be provided regarding this finding".
b) Meeting records indicated a concern regarding staff behaviour. The Director of Care identified verbally that this concern was voiced from a particular Resident.
c) The Director of Care confirmed the licensee did not follow the home's policy related to Management of Concerns/Complaints in response to this Resident's complaint related to staff. [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 plans, policies, protocols, procedures, strategies put in place by the home are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

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1. The licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter as evidenced by:
a) A review of resident's monthly weights report revealed that weights were not measured and recorded monthly for all residents.
b) A Resident did not have a weight measured and recorded for the months of January, February, March, May, August and September 2013. A November weight was not measured and recorded when reviewed November 15, 2013. Registered staff verified that the monthly weight should have been measured and recorded.
c) A second Resident did not have a weight measured and recorded for the months of April, July, August and September 2013. A weight recorded revealed this resident had lost weight since the previous weight was measured and recorded.
d) A third Resident did not have a weight measured and recorded for the months of February, July, August and October 2013.
e) A fourth Resident did not have a weight measured and recorded for the months of July, August and September 2013. A weight recorded for this Resident revealed the resident had lost weight since the previous weight was measured and recorded.
f) Interview with the Director of Care verified that monthly weights were not always measured and recorded in Point Click Care. [s. 68. (2) (e) (i)]

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 has a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that is both safe and palatable to the residents as evidenced by:
a) During the lunch meal service November 14, 2013, food items were being served at a temperature that was not safe and palatable. In the Lawson home area, several cold menu items were placed on top of the steam well cover with out any attempts to maintain temperatures. The puree potato salad was 13.4 degrees celsius, minced deli ham was 18.5 degrees celsius, regular potato salad was 17.0 degrees celsius and the minced salad was 13.5 degrees celsius. In the Ivey home area, the dietary aide confirmed that the puree sandwich was 14.0 degrees celsius when arriving on the floor and was placed in the freezer to cool the product to 6.8 degrees celsius.
b) A review of the temperature log in the main kitchen revealed that there were no temperatures taken and recorded at the end of the cooking process for any food items prepared. The Food Services Manager verified that no temperatures of any of the food items were taken prior to serving staff leaving the kitchen for the lunch meal on November 14, 2013. The Food Service Manager and residents interviewed indicated that food temperatures had been an ongoing concern in the home. [s. 73. (1) 6.]

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 has a dining and snack service that includes food and fluids being served at a a temperature that is both safe and palatable to the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies, that is secure and locked, that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy as evidenced by:
a) On November 13, 2013, a prescription medication was observed in the washroom of a Resident.
b) A Registered Practical Nurse confirmed on that date that the prescription medication should be stored in the medication room.
c) On November 14, 2013, the same prescription medication was observed again in this Resident's washroom. [s. 129. (1) (a)]

2. The licensee failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for storage or the drugs as evidenced by:
a) Six expired treatment creams and/or ointments were observed in the Kingsmill unit treatment cart that was in use by registered staff.
b) A Registered Practical Nurse confirmed the observation. [s. 129. (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug related supplies, that is secure and locked, that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy and that complies with manufacturer's instructions for storage or the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (1) Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of,
(a) all expired drugs; O. Reg. 79/10, s. 136 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs as evidenced by:
a) The Executive Director & Director of Care confirmed there is no written policy in place in the home related to the identification, destruction and/or disposal of expired drugs. [s. 136. (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 as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of all expired drugs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement

Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:

1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.

2. The system must be ongoing and interdisciplinary.

3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.

4. A record must be maintained by the licensee setting out,

i. the matters referred to in paragraph 3,

ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and

iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to maintain a record of the names of the persons who participated in evaluations, and the dates improvements were implemented as evidenced by:

a) There has been no evaluation of the Quality Improvement Program as confirmed by the Executive Director.

b) There has been no evaluation of the Skin and Wound Program as confirmed by the Associate Director of Care.

c) There has been no evaluation of the Abuse Prevention Program as confirmed by the Education Coordinator.

d) There has been no evaluation of the Infection Control Program as confirmed by the Infection Control Lead.

e) There has been no evaluation of the Training and Orientation Program as confirmed by the Education Coordinator. [s. 228. 4. ii.]

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 maintain a record of the names of the persons who participated in evaluations, and the dates improvements were implemented, to be implemented voluntarily.

WN #8: 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,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program; 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 failed to ensure there is an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control program as evidenced by:
a) The Administrator, the Director of Care and the Infection Control Lead confirmed that there is not an interdisciplinary infection control team in the home that meets at least quarterly. [s. 229. (2) (a)]

2. The licensee failed to ensure that staff participate in the implementation of the infection prevention and control program as evidenced by:
a) Observations in resident rooms on November 12, 13, 14, 2013 in all home areas revealed:
i) (semi private room) urine measuring container on the back of the toilet not labeled, unlabeled soap dish with semi-liquid soiled bar soap found on the counter in shared washroom
ii) soiled urinal on back of toilet, rubber gloves hanging on grab rails in washroom
iii) (semi private room) unlabeled bar soap, unlabeled visibly soiled comb on counter in shared washroom
iv) catheter tubing with urine in it and bag hanging on grab bar in washroom
v) bedpan on floor, urine measuring container on floor in washroom
vi) (semi private room) unlabeled denture cup on counter in shared washroom
vii)(semi private room) unlabeled combs on counter in shared washroom
viii) (semi private room) dirty and unlabeled combs and brushes and an unlabeled denture cup found on counter in shared washroom
ix) (semi private room) unlabeled soiled bed pan on back of toilet in a shared washroom
b) The Director of Care confirmed that personal items are to be labeled and urinals, bed pans and basins are to be single use only and cleaned after use daily on night shift. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is an interdisciplinary team approach in the co-ordination and implementation of the Infection Prevention and Control program and that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident as evidenced by:
a) A Resident's care plan indicated this Resident requires supervision or cues to transfer safely and was a 2 person physical assist for transferring.
b) This Resident's Safe Ambulation, Lifts and Transfers (SALT) assessment and SALT transfer logo in the resident's room indicates one person minimal assistance, intermittent assistance with cueing/supervision physical touch.
c) This Resident's current care plan indicated a high risk for falls, the Falls Intervention and Risk Management Policy (LTC-E-60) and the Director of Care indicated that a falling star sticker is placed on a resident's SALT logo in the room if they are a high risk for falls.
d) Observations on November 15, 2013 revealed that this Resident's SALT logo did not have a falling star on it. [s. 6. (1) (c)]

2. The licensee failed to ensure the plan of care set out clear directions to staff and others who provide direct care to the resident as evidenced by:
a) A Resident has been identified as requiring a precaution as per the high risk monitoring list and the Infection Control Lead.
b) This Resident's plan of care did not include this precaution or directions to staff regarding this precaution, this was confirmed by the Infection Control Nurse. [s. 6. (1) (c)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure any written complaints that have been received concerning the care of a resident or the operation of the home were immediately forwarded to the Director as evidenced by:
a) An electronic letter of complaint was received by the home from a family member of a Resident.
b) The Executive Director and the Director of Care confirmed the letter was not forwarded to the Director. [s. 22. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented as evidenced by:
a) A Resident had a wound that was resolved. Review of the resident health care record and interview with one staff confirmed the written plan of care dated at the time when this resident had altered skin integrity did not include dietary interventions related to nutrition and hydration to promote wound healing. [s. 50. (2) (b) (iii)]

b) A Resident experienced a skin tear/abrasion. Review of the resident health record and interview with two staff confirmed this resident has not been assessed by a registered dietitian [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been reassessed at least weekly by a member of registered nursing staff as evidenced by:
a) A Resident experienced a skin tear/abrasion. Review of the health care record and interview with one registered nursing staff confirmed the resident's wound has not been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee did not ensure that Resident's Council concerns or advice were responded to in writing within 10 days of receiving the concerns or advice.
a) A review of the Resident's Council meeting minutes revealed that there were no written responses to resident's concerns or advice.
b)The Recreation Manager confirmed that the home responded to Resident's Council concerns or advice verbally at the next scheduled Resident Council meeting and did not provide written responses to the Resident's Council concerns or advice within 10 days of receiving the concerns or advice. [s. 57. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared and served using methods to preserve taste, nutritive value, appearance and food quality as evidenced by:
a) The home did not follow their standardized recipe for pureed ham and cheese sandwich for the lunch meal November 14, 2013. The recipe directed staff to bake bread with milk in the oven, melt margarine and stir completely. Staff were to add ham and cheese in the food processor and add milk, margarine and mayonnaise and blend smooth until a pudding-like consistency was reached. The recipe directed staff to serve the the filling along with the bread. During production, it was observed that the Cook blended the bread with water and poured the bread in pans. The Cook blended the minced ham and cheese together and poured the filling into each pan of bread and mixed together. The end product was noted to be runny compromising the taste and nutritive value of the sandwich.
b) The recipe for the regular ham and cheese sandwich directed staff to add ham, cheese, lettuce and tomato to the sandwich however, the Cook only added ham and cheese compromising the taste and nutritive value.
c) The consistency of thickened fluids was not prepared to the appropriate consistency when observed in the Harris dining room during the lunch meal November 12, 2013. The inspector observed the thickened fluids to be of pudding thick fluids however; the dietary aide confirmed that there were no residents on that home area that required pudding thick fluids. The Food Services Manager and Dietary Aide verified that the consistency of thickened fluids varied depending on the staff member who prepared the product despite having directions available for staff to follow. [s. 72. (3) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (2) The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director. O. Reg. 79/10, s. 103 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that upon receipt of a written complaint the licensee reports to the Director along with a written report documenting the response the licensee made to the complainant immediately upon completing the licensee's investigation into the complaint was submitted as evidenced by:
a) The licensee received an electronic written letter of complaint dated May 22, 2013 regarding a Resident.
b) An interview with this Resident's family member on November 14, 2013 revealed that they had not received a response from the licensee regarding his letter of complaint dated approximately 6 months prior.
c) The Executive Director of care confirmed on November 15, 2013 that she was currently working on the follow up and response to the letter of complaint dated approximately 6 months prior and that she had not yet responded to the complaint and had not submitted the response to the Director. [s. 103. (2)]

Issued on this 4th day of December, 2013

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

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) :	RHONDA KUKOLY (213), CARMEN PRIESTER (203), CAROLEE MILLINER (144), TAMMY SZYMANOWSKI (165)
Inspection No. / No de l'inspection :	2013_229213_0053
Log No. / Registre no:	L-000907-13
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 29, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	McGARRELL PLACE 355 McGarrell Drive, LONDON, ON, N6G-0B1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LYNN MELLOWS

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that 100% of staff complete all mandatory education in 2014 as per LTCHA 2007, c.8, s.76. (4). This legislation has not been complied with in 2012 and 2013 as evidenced by the training and education completion records for both years. The plan shall include the following:
a) Timelines for the completion of the education of 100% of staff as per LTCHA 2007, c.8, s.76. (4) (including all staff absent on the day of education) by March 31, 2014.
b) A description of the method of education.
c) Who is responsible for the management of this education in the home including completion, monitoring and follow up.

This plan is to be submitted electronically to Rhonda.kukoly@ontario.ca by December 20, 2013.

Grounds / Motifs :

1. The licensee failed to ensure that all staff received training annually related to the requirements under o.Reg 79/10, r.219(1) as evidenced by:
Documentation regarding training reveals the following percentages of staff participation in each type of training for the year 2013:
Resident Bill of Rights: 37%
Prevention of Abuse Training: 35%
Mandatory Reporting: not listed as part of their education program.
Whistle Blower protection: not listed as part of the Education Program
Minimizing of Restraints: 8%

Fire Prevention and safety: 43%
Evacuation Procedures: 37%
Concern/complaint Management: 43%
Safe use of Equipment: 0%
Cleaning and Sanitization of Equipment: 47%
This was verified by the Education Coordinator.

Documentation regarding training reveals the following percentages of staff participation in each type of training for the year 2012:
Prevention of Abuse : 35%
Resident Rights: 37%
Falls:0%
Restraint Use: 0%
Infection Control:
Just Clean Your Hands: 3%
Outbreak Management:1%
Pain: 5%
Palliative: 15%
Safe and Correct Use of Equipment: 0%
Cleaning and Disinfecting: 2%
Modes of transmission: 4%
Heat Risk: 0%
Continence:39%
Responsive Behavior:19%
This was verified by the Education Coordinator.

4 out of 9 staff interviewed (including 6 PSWs, 1 dietary aid, 1 RPN and 1 housekeeping staff) did not recall having training or education in the prevention of abuse in the last year.
(144)

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

and the Director

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 29th day of November, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RHONDA KUKOLY

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