Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 10, 2014	2014_214146_0026	H-001589-14	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

GARDEN CITY MANOR
168 Scott Street St. Catharines ON L2N 1H2

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

BARBARA NAYKALYK-HUNT (146), CATHIE ROBITAILLE (536), MELODY GRAY (123), MICHELLE WARRENER (107)

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 18, 19, 20, 21, 24, 25, 26, 27, 2014

This inspection was conducted concurrently with Follow-Up inspections H-000287-14, H-000282-14, H-001123-14 and H-001124-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Services Manager (FSM), Registered Dietitian (RD), Environmental Services Manager (ESM), Program Manager, registered staff, Personal Support Workers (PSW's), dietary staff, housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
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
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

17 WN(s)
11 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_247508_0003	146
O.Reg 79/10 s. 72. (3)	CO #001	2014_191107_0018	107
O.Reg 79/10 s. 72. (3)	CO #002	2014_191107_0018	107

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. 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 21. Sleep patterns and preferences.

A) A random sample of twenty-five residents' plans of care were reviewed to measure the success of the home's March 21, 2014 compliance plan submitted as requested in the previous compliance order of February 2014. The plan had indicated that all residents' plans of care would be updated to reflect sleep and rest assessments and preferences. However, of the sample reviewed, residents #052, 053, 054, 055, 046, 056, 057 and 060 did not have sleep and rest patterns and preferences addressed in their plans of care. The DOC confirmed that sleep and rest had not been addressed with all residents.

B) Of those residents who did have completed sleep and rest assessments and preferences on their plans of care, residents #050, 021 and 007 plans of care were in conflict with their assessed sleep and rest preferences. The residents' assessments indicated that they did not wish to be wakened until between the hours of 0730 and 0830 in the morning. All three of these residents were observed to be on the night shift care list and were awakened for personal morning care between 0600 and 0700. The PSW's on night shift confirmed that the residents were to be wakened in the morning as part of their assignment regardless of the residents' preferences. [s. 26. (3) 21.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 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 there was a written plan of care for each

resident that set out, (c) clear directions to staff and others who provided direct care to the resident. 2007, c. 8, s. 6 (1).

A) Resident #008's plan of care directed staff to practice safe sit to stand transfers with one staff and, under the same focus, stated that the resident needed two staff for sit to stand transfer. Under the focus of transfers, staff were directed to use two staff to transfer. Registered staff confirmed that the directions were unclear and confusing. (146)

B) The goals identified on resident #042's plan of care were to maintain adequate food and fluid intake to meet estimated nutritional requirements and for weight maintenance. The resident's plan of care also directed staff to provide "comfort nutrition" with no aggressive treatment for re-hydration and nutritional intake. The resident had a significant weight loss over one year. The RD stated the goal for the resident since April 2014 was for comfort nutrition. The licensee has failed to ensure that the plan of care for resident #042 provided clear direction to staff providing care to the resident in relation to their nutritional status and goals. (107)

C) Resident #008's plan of care, under the focus of falls risk, directed staff to see the toileting focus for a toileting schedule. However, there was no toileting schedule under the toileting focus. Staff confirmed that this direction was confusing and did not provide clear direction. (146)

D) Resident #044's plan of care directed staff to provide both a minced diet texture and a pureed diet texture. The plan of care did not provide clear direction for staff in relation to the two diet textures. (107) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's nutritional needs and preferences.

A) On November 27, 2014, resident #034 stated they mainly ate only a certain vegetable. The resident stated they enjoyed fish, chicken and beef; however, did not like the way the home prepared it. The resident stated they preferred only plain meat without any sauces at meals. The plan of care identified the resident ate chicken; however, there was no plan in place to ensure an appropriate meal was available to the resident. The plan of care was not based on the resident's preference to consume only plain meats at meals and to ensure that an appropriate meal was available to the resident.

B) Resident #034's plan of care was not based on an assessment of meeting the

resident's micronutrient requirements. Prior to admission, the resident stated they had been taking a multivitamin/mineral supplement which was discontinued upon admission to the home. The resident was only consuming one meal daily (their preference) and consumed mainly a certain vegetable at the meal. The resident was not ordered a multivitamin/mineral supplement and the resident was not consuming foods according to the planned menu. Nutritional assessment documentation did not reflect an assessment of the resident's nutritional requirements versus intake and did not identify that the resident's preferences for meals were planned for.

C) On a date in November 2014 resident #034 stated they were concerned because they were not offered a meal if they chose not to go to the dining room for meals. The resident was concerned with other residents' reactions to a symptom of their medical diagnosis. Documentation in the resident's progress notes indicated the resident was not offered a meal when they refused to go to the dining area. Interview with the DOC identified that the resident should have been offered a meal and food was not to be withheld when the resident refused to eat in the dining room. Documentation did not reflect that strategies were in place to address the resident's anxiety over going to the dining room. [s. 6. (2)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A) The health record of resident #034 indicated that the resident fell resulting in an injury. The resident was assessed by the physiotherapist who determined that the resident was at a high risk for falls. The resident's nursing care plan indicated that the resident was assessed as a low risk for falls.
The home did not ensure that the physiotherapy and nursing fall risk assessments of the resident were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) Resident #002's plan of care directed staff to apply a certain intervention every two hours. On a date in November 2014, the resident was observed to be without the intervention for four hours. The PSW confirmed that the intervention had not been done for four hours on that date. (146)

B) Resident #002's plan of care required specific texture for food and fluids. The

therapeutic extension menu for the lunch meal on a date in November 2014 identified that residents receiving thickened consistency fluids were to receive either chiffon or mousse for dessert instead of jello or ice cream (as planned for the regular texture menu). The resident's plan of care stated the resident was also to receive a labeled specific dessert with each meal. Staff stated the labeled specific food was not available at snack or at the end of the meal (had run out). Staff provided the resident with jello; however, residents requiring thickened fluids were not to receive the jello as per the home's therapeutic extension menu. The resident did not receive care as set out in the plan of care. (107)

C) The plan of care for resident #008 directed staff to provide a specific intervention after meals. On two dates in November 2014, the resident was observed to not have the intervention used after breakfast or lunch meals. The staff confirmed that the resident had not received the intervention on those dates or any other dates. The resident did not receive care as set out in the plan of care.

D) The licensee failed to ensure that the care set out in the plan of care for resident #025 was provided to the resident as specified in their plan. The resident was at high risk for falls; had sustained multiple falls and therefore a specific strategy was being used to alert staff when resident tried to get up unassisted as directed in the care plan. Documentation in the progress notes on a date in June 2014 identified that the strategy had been removed due to frequent alerts. Registered staff verified that the specific strategy was being turned off because it was going off too frequently. The resident sustained an unwitnessed fall the day prior. [s. 6. (7)]

5. The licensee has failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care

A) Resident #008's plan of care indicated that staff "see the check and change program" for toileting and continence management of the resident. Three out of three PSW's interviewed did not know what the check and change program was nor that it was on the plan of care and kardex. Registered staff were also interviewed. One nurse stated that it was a program to toilet a resident who used a mechanical lift every two hours. Another nurse stated she had heard the term but was unsure what it meant. According to the continence program provided by the ADOC, the "check and change program" refers to checking a resident's continence product and changing them at regular intervals. The staff were not kept aware of the contents of the resident's plan of care.

B) Resident #008's plan of care directed staff to put the resident to bed after all meals for a rest. Direct care givers and registered staff on the unit confirmed that they were unaware of this specific direction in the plan of care and had not been doing it. [s. 6. (8)]

6. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when, (b) the resident's care needs changed or care set out in the plan was no longer necessary; 2007, c. 8, s. 6 (10).

A) Resident #002's current plan of care directed staff to monitor for and document signs and symptoms of drug related complications associated with the use of psychotropic drug use. A health record review indicated that the resident's psychotropic medications were discontinued seven months ago and not restarted. The resident is currently on no psychotropic medications as confirmed by registered staff and the health record. The plan of care was not revised when the resident's care needs changed. (146)

B) In November 2014 the document the home referred to as the care plan identified that resident #008 required a certain intervention and also stated the intervention was not always required. Interview with the Physiotherapist on November 24, 2014, identified that the intervention was implemented on a trial basis from April to September 2014; however, the intervention was discontinued in September when it was found to be ineffective. The resident's plan of care was not revised when the intervention was no longer necessary. (107)

C) Resident #008's current plan of care directed staff to monitor for drug related complications associated with the use of psychotropic drug use. The resident is not currently on any psychotropic medication. The medication was discontinued eight months ago. Staff confirmed that the plan of care was not revised when the care set out in the plan was no longer necessary. (146) [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 there is a written plan of care for each resident that sets out, (c) clear directions to staff and others who provide direct care to the resident; that the plan of care is based on an assessment of the resident and the resident's needs and preferences; that the care set out in the plan of care is provided to the resident as specified in the plan; that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care; that the resident is reassessed and the plan of care reviewed and revised when, (b) the resident's care needs change or care set out in the plan is no longer necessary,, to be implemented voluntarily.

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is: (b) complied with

The home's policy Medication / Treatment Standards #LTC-F-20 was reviewed and it included: "Resident confidential information will be protected during and after medication administration."
On November 26, 2014 during a medication pass observation, the registered staff was observed disposing of residents' empty medication pouches which had the residents' personal health information written on the outside in the general garbage bag at the side of the medication cart along with spoons and medication cups.
The registered staff was questioned regarding the disposal of the residents' empty medication pouches and they confirmed that the residents' medication pouches were being disposed of in the regular general garbage.
On November 27, 2014 the inspector questioned another registered staff on the second floor related to the disposal of residents' empty medication pouches and they reported that after the administration of medications, the residents' empty medication pouches were thrown into the garbage.

The home did not follow their medication policy and procedures to protecting residents' confidential information. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is:
(b) complied with, to be implemented voluntarily.

WN #4: 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.

A) In November 2014, the following was observed:
i) a blue shower chair in the Short Hills spa was observed to have a rip in the right side of the seat;
ii) the privacy curtain rod at entrance of the spa was rusted;
iii) varnish was peeling on lower legs of two wooden chairs against wall outside the Orchard Cafe;
iv) flooring was cracked at the right side along the wall in the shower area of the DeCew home area spa;
v) one centre top drawer was missing from vanity at sink in the spa resulting in a gap of approximately two feet;
vi) light fixture cover was missing at entrance of the Montebello House spa;
vii) shower chair surface was worn;
flooring was cracked at shower entrance;
and
viii) the soap holder in shower area was rusting.

The home failed to ensure that the home, furnishings and equipment were kept in a good state of repair. [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 the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to the nursing program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) Documentation in resident #025's progress notes in June 2014 identified that the resident's family was concerned about bruising on the resident. There was no documentation about the bruising or follow up notes about the bruising. Interview with registered staff identified they followed up with the resident and the resident did not actually have bruising. There was no documentation in the resident's record or staff daily communication records to support that the bruising was followed up or assessed.

B) Documentation in resident #025's progress notes on a date in June 2014 identified the resident had pain and directed staff to monitor. There was no follow up documentation in the progress notes related to the pain until several days later when the painful area was noted to be swollen and bruised. The resident had a fracture confirmed by xray several days after the swelling was noted. Documentation in the staff communication book identified the resident received medication for pain (as needed order) when the resident first complained of the pain, however, there was no documentation about the painful area in the progress notes until four days later. Documentation on the Medication Administration Record (MAR) for June 2014 did not reflect that the medication had been given or the resident's response to the medication. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any actions taken with respect to programs, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received preventive and basic foot care services, including the cutting of toenails, and fingernail care, including the cutting of fingernails.

A) In November 2014, resident #034 was observed with long fingernails (curving over the finger) that were soiled with black residue under the nails. The resident stated that they would like their nails shorter but staff did not cut them frequently. The resident also stated their toe nails were uncomfortable and needed to be cut more frequently. The resident's plan of care directed staff to clean and trim the resident's nails on bath days (twice weekly) and that the spa team were to provide foot care. Documentation in the Point of Care (POC)documentation system over the past 30 days indicated that the resident's finger and toenails were trimmed on one date in November 2014 only (no refusals).

B) In November 2014, resident #031 was wearing open toed shoes and their toenails were long and curving over their toes. The resident's plan of care directed staff to cut and clean the nails on bath days. Documentation in the POC documentation system indicated that the resident's toenails were not cut for over one month and documentation did not reflect that trimming was refused.

C) In November 2014, resident #022 was observed with long dirty fingernails. The resident's plan of care directed staff to clean and cut fingernails on bath days. The resident refused twice in one week, however, the length of the nails was more than one week of growth. The resident did not have documentation to support that toenails had been cut for over one month. Staff observed the nails and confirmed they required trimming and cleaning.

D) On two dates in November 2014, resident #051 was observed to have long jagged toenails. The resident's plan of care required staff to cut and clean the resident's nails on bath days. The resident refused on November 5, 12, 26, 2014; however, documentation did not reflect that the nails were cut on any of the other bath days for over one month. No strategies were in place on the resident's plan of care around behaviours related to nail care.

E) Documentation did not reflect that resident #021 had their toenails trimmed for over one month. The resident's plan of care stated the resident was to have their nails trimmed by staff on bath days. The resident refused on November 9 and 23, 2014; however, documentation did not reflect that toenail trimming was offered on the other bath days that month. [s. 35.]

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 of the home receives preventive and basic foot care services, including the cutting of toenails, and fingernail care, including the cutting of fingernails, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was dressed appropriately, in his or her own clean clothing and in appropriate clean footwear.

A) Resident #021 was observed with dried food residue on their pants and a t-shirt soiled with mucus and dried on residue/food/stains on a date in November 2014 at 1102 hours. The resident was sitting in-front of the nursing station all morning wearing the same soiled clothing and was put to bed wearing the same clothing at 1532 hours.

B) In November 2014, at 1030 hours resident #042 had yogurt on their shirt and eggs on their face from the breakfast meal. The resident was wearing the same clothing at the noon meal and the egg remained on the resident's face during the lunch meal.

C) In November 2014 at 1419 hours and again at 1529 hours, resident #045 was observed with dried food residue from the lunch meal on their clothing. The resident's clothing was not changed during that time.

D) In November 2014 at 1516 hours, resident #046 was observed with soiled clothing and again after working with the physiotherapy assistant. The resident was not changed after being returned to their room.

E) In November 2014 at 1030 hours resident #020 was observed with soiled clothing from the breakfast meal. The resident's clothing was not changed after the meal.

F) In November 2014 at 1055 hours resident #047 was observed with a large stain on their pants spanning both legs and between the resident's legs. The resident was toileted prior to the lunch meal; however, their pants were not changed. The resident was still in their soiled pants at 1645 hours.

PSW staff interviewed stated that soiled clothing was to be changed as soon as it was noticed and clothing soiled from meals was to be changed right after the meal. [s. 40.]

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 of the home is dressed appropriately, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.

WN #8: 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,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that (d) any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load

A) Resident #008's plan of care indicated that the resident was totally dependent on staff for repositioning. On a date in November 2014, the resident was observed to be sitting with head and neck leaning forward towards the knees from 0715 to 1445 hours. Staff confirmed that the resident was not repositioned every two hours and may have had only one change in position when checked for incontinence around 0900. [s. 50. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that (d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, to be implemented voluntarily.

WN #9: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who was incontinent had an individualized plan of care to promote and manage bowel and bladder continence.

A) Resident #002's plan of care contained no directions to staff to manage bowel incontinence even though the MDS assessment indicated the resident was incontinent of both bowel and bladder.

B) Resident #002's plan of care for urinary incontinence directed staff to see the two person toileting list. When observed, the "Two Person Toileting List" contained a list of residents who required 2 staff for toileting. There were no directions as to frequency of toileting.

Resident #002 did not have an individualized plan to manage bowel and bladder incontinence. This information was confirmed by registered staff. [s. 51. (2) (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 resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there were standardized recipes and production sheets for all menus that provided clear direction to staff preparing and serving meals. Production sheets currently used by the home did not provide clear direction in relation to portioning/planning for each dining area and advance preparation of menu items. At meal service on two dates in November 2014, the home ran out of items in the second floor dining area and had to call the kitchen to obtain more, creating a delay in the meal service. Direction was not provided for quantities of texture modified menu items and specialty items to send to each dining area. Staff were also preparing some items a day in advance; however, direction to do so was not provided on recipes or production sheets. [s. 72. (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 there are standardized recipes and production sheets for all menus that provide clear direction to staff preparing and serving meals, to be implemented voluntarily.

WN #11: 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: 7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that sufficient time was provided for all residents to eat at their own pace at the lunch meal on a date in November 2014.
Resident #044 was not finished consuming their entree at 1300 hours (still had several bites of their meal left and the resident was actively eating) when a PSW came and offered the resident dessert several times despite the resident still eating. The PSW then came back and removed the resident's plate and placed the resident's dessert on the table. The resident had not stated they were finished their meal yet and still had food on

their plate. The meal service was rushed for this resident. The resident was unable to tell the inspector if they were finished with their meal or if they felt rushed. [s. 73. (1) 7.]

2. The licensee has failed to ensure that meals were served course by course in one dining area.

A) All courses (soup, entree, dessert) were served at the same time for residents dining in that area. Registered staff interviewed stated that all items were served together as it was easier for the staff and timing of meals in that dining area. During interview, the FSM stated that Cambro carts were purchased specifically for that dining area so that meals could be kept hot/cold while residents were dining course by course.
i) Resident #049 had all of their courses placed on the table at the beginning of the meal service. The resident consumed their soup while their hot entree sat on the table. When interviewed, the resident stated their entree tasted good but was cold.
ii) Resident #050 had their soup, entree, and dessert in-front of them on the table. The resident was observed mixing their soup with their peaches at the table. Staff stated the resident always mixed items together if there were more than one item at a time. The resident's plan of care identified placing appropriate foods one at a time.
iii) Resident #027 had all of their items provided together on the table. The resident's plan of care directed staff to provide small amounts of food at a time to reduce speed of eating. Staff were also using a large tablespoon to feed the resident.
iv) The FSM stated, to their knowledge, there were no residents in that dining area that required all meal items served together. [s. 73. (1) 8.]

3. The licensee has failed to ensure that proper techniques, including safe positioning, were used to assist resident #042 with the lunch meal on a date in November 2014. The resident was observed being fed with their chin pointing towards the ceiling and their tilt chair was not in an upright position. The resident's head rest on their chair was not in a position that was supportive of the resident's head. The resident appeared to be uncomfortable and was wincing when trying to swallow with their head tilted up toward the ceiling. Staff stated it was difficult to position the resident and the resident slid out of position regularly. Staff continued to feed the resident with their chin toward the ceiling. [s. 73. (1) 10.]

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 sufficient time is provided for all residents to eat at their own pace, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures were developed and implemented for, (a) cleaning of the home, including, common areas and staff areas, including floors, contact surfaces and wall surfaces.
The home's policy, "Contract specifications main kitchen and serverys, ES C-30-105", stated that the main kitchen floor would be scrubbed monthly by housekeeping and the kitchen exhaust vents would be checked monthly by housekeeping and cleaned as

required.

A) The kitchen floor was observed to be coated with a build up of residue and did not appear clean. The ESM stated that due to the elevator shutdown the monthly cleaning was not completed. The ESM also stated that the floors were to be deep cleaned by Housekeeping once every six months. A documented record was not available to confirm when the floors were deep cleaned. The floors were not scrubbed with the same frequency as required by the home's policy and appeared unclean.

B) The exhaust vents above the stove were coated in a thick layer of dust and residue. The ESM stated that dietary staff were responsible for cleaning the vents and that a special tool was purchased for removing the vents. Dietary staff stated they used to clean the vents previously; however, they no longer did the cleaning and it was the responsibility of the housekeeping department. Staff confirmed the vents had not been cleaned as needed. [s. 87. (2) (a) (ii)]

2. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of:
i. resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
ii. supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
iii. contact surfaces.

On November 18, 2014 and November 26, 2014 the spas on the Short Hills House, the De Crew home area, and the Montebello House home areas were observed.
A) In the Short Hills House spa a build up of dirt was observed around shower area at lower tiles and where the tiles met the wall. There was a dirt and rust build-up in a gap of approximately one inch between the tiles at the base of the bath tub. Dirt build-up was observed behind the entrance door at wall inside spa. White commode was soiled with fecal matter under seat at right front section and side. There was a soiled brown area on the left side of the seat of the shower chair.

B) In the DeCew home area spa there was dirt build-up in the right and left corners of the shower. The shower area walls were dirty and there was a brown soiled area on the left, right and centre of seat of the shower chair.

C) Burgoyne House Spa was inspected and shower chair seat was soiled. The walls in the shower area were dirty. There was a dirt build up in corners of the shower area. Tub lift chair was dirty.

D) Montebello House spa was inspected and dirt build-up was observed behind entrance door. Feces was observed under seat of commode chairs and toilet seat. Soiled brown area was observed around the center of bath chair seat. Shower chair surface was soiled.

On November 26, 2014 above spas were inspected with the Infection Control Nurse and the ESM and they confirmed the above observations and that it was the home's expectation that the staff clean and disinfect all resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs; supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and contact surfaces between each use as per the home's policies and procedures.

E) Resident #021 was observed with a dirty wheelchair (sides and cushion) on November 24, 2014 at 1002 hours. The wheelchair was recorded as being cleaned on November 23, at 0148 hours. The wheelchair looked like there was build up on sides of the wheelchair and the cushion had dried on food on it. (107)

F) Resident #046 was observed November 24 and 25, 2014 at 1030 hours with a soiled wheelchair. Documentation stated the wheelchair was cleaned November 25, 2014 at 0506 hours. The wheelchair had dried on food stains and build up on the sides of the wheelchair. (107)
The home did not ensure that the procedures for cleaning and disinfection of resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs; supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and contact surfaces were implemented. [s. 87. (2) (b)]

3. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) of the Act, the licensee shall ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours as evidenced by:

A lingering offensive odour was noted on the second floor of the home from November 19, 2014 through November 26, 2014. The presence of the odour was confirmed with Nursing Department staff and ESM. The Environmental Services Manager confirmed

that the home had policies and procedures for addressing incidents of lingering offensive odours. The home's policy Quality Management Urine Odour Management Urine Odour Audit # ES C-25-15 which included "To ensure all lingering urine odours of the home are investigated and eliminated. " was reviewed.

The home did not implement the procedures for addressing incidents of lingering offensive odours on the second floor from November 19, 2014 through November 26, 2014. [s. 87. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, procedures are developed and implemented for, (a) cleaning of the home, including, common areas and staff areas, including floors, contact surfaces and wall surfaces, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including hygiene and grooming, on a daily basis.
Several female residents were noted to have long facial hair that was not removed. The home's policy on personal care stated that facial hair was to be removed at morning care. During interview, registered nursing staff and PSW's stated that facial hair on women was to be removed whenever it was noticed. Staff stated they were not aware of any female residents that did not want their facial hair removed.

A) Resident #032 was observed with facial hair on November 18, 2014 at the noon meal and at 1422 hours. Documentation in the resident's progress notes on November 12, 2014 identified the resident's family wanted the resident shaved routinely and the resident's plan of care stated the resident was to be shaved daily. The resident's facial hair (chin and upper lip) was quite long when observed (more than daily growth).

B) Resident #028 was observed with long facial hair on November 19, 2014 at 1030 hours. The resident was dependent on staff for hygiene and grooming and could not voice their preferences.

C) Resident #025 was observed with long facial hair on November 19, 2014 at 1040 hours. The resident was dependent on staff for hygiene and could not voice their preferences.

D) Resident #026 was observed with long facial hair on November 19, 2014 at 1040 hours. The resident required total assistance with personal hygiene and was unable to voice their preferences.

E) Resident #033 was observed with facial hair on November 18, 2014 at 1426 hours. The resident required staff assistance with personal hygiene from start to finish and didn't voice their preferences to the inspector when asked.

F) Resident #044 was observed with long facial hair on November 24, 2014 at 1140 hours. The resident required full assistance with grooming and was unable to voice their preference to the inspector. [s. 32.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that action was taken and outcomes were evaluated for resident #002 after a 5 % weight change over one month and other weight changes that compromised the resident's health status.
The resident's plan of care in May 2014 required weight maintenance between a goal weight range of 65-70kg. The resident had a significant weight loss of 9.7% over one month from April to May 2014 (69.1kg to 62.4kg). A reweigh was requested by the RD in May; however, action was not taken at that time. The RD followed up at the nutritional review in June 2014, and confirmed the weight loss from the previous month. Nutrition interventions were not revised when the resident fell below their goal weight range; only the goal weight range was lowered. The resident continued to have slow gradual weight loss until November 2014 (55.8kg) when nutrition interventions were implemented after skin issues developed. The resident had documentation of poor intake and difficulty feeding in August 2014 with a 4.9% weight loss over one month without a revision to the resident's nutritional interventions. The resident's goal weight range was reduced in June, July and November while the goal for the resident had been weight maintenance. The resident lost 19.2% of their body weight over 7 months. The RD stated they were unsure of what interventions to try due to the resident's restricted menu and responsive behaviours. [s. 69.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.

One 9.46 litre bottle of Quick Fill 310 Neutral Cleaner Super Concentrate #6238505 with MSDS reference on bottle which was approximately half full was observed in an unlocked cupboard below sink in the second floor residents' kitchenette. Residents were observed in the vicinity. A housekeeping staff member was interviewed and they confirmed that the product was a hazardous substance and that it should be kept inaccessible to residents at all times. [s. 91.]

WN #16: 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 has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.
The medication room was observed with the Infection Prevention and Control Registered Nurse who informed inspector that narcotic and controlled substances for destruction are stored in a locked safe sitting on the counter top and not in a double-locked stationary cupboard in the locked area. This information was confirmed with the ADOC.
The locked safe was observed on the counter top in the Medication Room. [s. 129. (1) (b)]

WN #17: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.
The written documentation provided by the home in the Long-Term Care Home Licensee Confirmation Checklist-Infection Prevention and Control was reviewed and it was noted that residents were not offered immunization against tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
The home's Infection Control Nurse was interviewed and they confirmed that the home did not offer residents immunization against tetanus and diphtheria vaccine boosters every 10 years for continued protection in accordance with the publicly funded immunization schedules. [s. 229. (4)]

Issued on this 18th day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BARBARA NAYKALYK-HUNT (146), CATHIE ROBITAILLE (536), MELODY GRAY (123), MICHELLE WARRENER (107)
Inspection No. / No de l'inspection :	2014_214146_0026
Log No. / Registre no:	H-001589-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 10, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	GARDEN CITY MANOR 168 Scott Street, St. Catharines, ON, L2N-1H2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KIM WIDDICOMBE

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)

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0003, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
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.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Order / Ordre :

The licensee shall:
1. review all residents' plans of care and ensure that the plans include each resident's assessed sleep and rest patterns and preferences;
and
2. ensure that the residents' preferences are reflected in those plans of care
and
3. develop a process to maintain compliance with all current and new residents.

Grounds / Motifs :

1. Previously issued February 2014 as a CO and November 2012 as a VPC.

The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 21. Sleep patterns and preferences.

A) A random sample of twenty five residents' plans of care were reviewed to measure the success of the home's March 21, 2014 compliance plan submitted as requested in the previous compliance order of February 2014. The plan had indicated that all residents' plans of care would be updated to reflect sleep and rest assessments and preferences. However, of the sample reviewed, residents #052, 053, 054, 055, 046, 056, 057 and 060 did not have sleep and rest patterns and preferences addressed in their plans of care. The DOC confirmed that sleep and rest had not been addressed with all residents.

B) Of those residents who did have completed sleep and rest assessments and preferences on their plans of care, residents #050, 021 and 007 plans of care were in conflict with their assessed preferences. The residents' assessments indicated that they did not wish to be wakened until between the hours of 0730 and 0830 in the morning. All three of these residents were on the night shift care list and were awakened for personal morning care between 0600 and 0700. The PSW's on night shift confirmed that the residents on the night shift list were to be wakened in the morning as part of their assignment regardless of the residents' preferences.

(146)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 30, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 10th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BARBARA NAYKALYK-HUNT

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