Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Nov 30, 2015	2015_332575_0017	021569-15	Resident Quality Inspection

Licensee/Titulaire de permis

THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

AU CHATEAU
100 MICHAUD STREET STURGEON FALLS ON P2B 2Z4

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

LINDSAY DYRDA (575), MONIKA GRAY (594), TIFFANY BOUCHER (543)

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): September 14-18 and 21-25, 2015

During the course of the inspection, six critical incidents, one complaint, and a follow-up to two previous orders were inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Supervisor, Coordinator of Resident Services, RAI-MDS Coordinator, Environmental Services Manager (ESM), Maintenance and Housekeeping staff, Infection Prevention and Control (IPAC) Coordinator, Human Resources staff, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Activity staff, Family Members, and Residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **15 WN(s)**
- **8 VPC(s)**
- **2 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 #002	2015_282543_0008	543

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

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

Specifically failed to comply with the following:

s. 6. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

During stage 1 of the Resident Quality Inspection (RQI), S #115 indicated that resident #008 sustained a fall in 2015. The inspector reviewed the home's internal incident report filled out four days after the fall, which indicated that the resident attempted to get up on their own and sat on the floor next to their bed. This incident report identified that the resident was barefoot at the time of the fall.

Inspector #543 reviewed the resident's most recent care plan, specifically related to falls and/or mobility, which indicated that this resident required antislip slippers when in bed. The incident report indicated that the resident was not wearing their antislip slippers when in bed, therefore the care was not provided as planned. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care, was provided to resident #001 as specified in the plan.

On five occasions throughout the inspection, Inspector #575 observed resident #001 in their wheelchair with a device applied.

The inspector interviewed S #102 regarding the device. S #102 indicated that the device was used at all times when the resident was up in their chair. S #102 further indicated that the device was used to help the resident during meal time and the staff used it for positioning. S #102 indicated that the resident was dependent on staff for care and that S #102 reviewed the type of care to provide to the resident by reviewing the resident's care plan.

During an interview, S #103 indicated that the resident's device was not a restraint, that the resident would not be able to remove the device, and that it was used for positioning and for assisting with feeding the resident. S #103 was not able to find the use of the device in the resident's care plan.

During an interview, S #107 indicated that the use of the device should be in the resident's care plan. S #107 indicated that if it was not in the care plan, then staff should not apply it. S #107 confirmed to the inspector that the use of the device was not in the resident's plan of care. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care, was provided to resident #003 as specified in the plan.

On three occasions, Inspector #575 observed resident #003 in their wheelchair with a device applied. The inspector reviewed the resident's plan of care which indicated that the resident had the device used as a restraint. Upon further review, the documentation identified an additional intervention, to be implemented daily. The inspector reviewed the documentation for a period of approximately 21 days regarding this intervention and noted that during that period, it was only implemented on one occasion.

During an interview, S #119 indicated that the item to be used for the intervention was not always available, therefore the resident did not always have it.

S #116 confirmed that the intervention was not provided to the resident as ordered. [s. 6. (7)]

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to

suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #543 reviewed a critical incident (CI) regarding alleged staff to resident abuse/neglect that occurred in 2015. The CI indicated that resident #014 reported that they did not want to receive care from a certain staff member because that staff member had told the resident not to ring their call bell, therefore this resident was afraid to use their call bell for fear of getting in trouble.

The inspector reviewed documentation related to the above incident which described that a staff member told the resident that they would not provide them with care and that they would have to wait until the next shift staff came on. The resident also stated that the staff member told them to stop using their call bell and that they were not going to help them to bed.

Further documentation revealed that an investigation was initiated and the home found that the staff member's behaviour was negligent and resulted in disciplinary action. The CI indicated the date that the incident occurred, however the incident was not reported to the Director until approximately 36 hours later. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #575 reviewed a CI regarding an allegation of staff to resident abuse. The CI indicated that resident #018 accused S #118 of injuring them while providing the resident care. The accusation was reported to S #117, however the incident was not reported to the Director until two days later.

During an interview, the DOC confirmed that the incident was not reported to the Director until two days after the allegation was brought forward. [s. 24. (1)]

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the

suspicion and the information upon which it was based to the Director:

Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #575 reviewed a CI regarding an allegation of staff to resident abuse. The CI indicated that resident #017 accused S #114 of treating the resident in an inappropriate manner and was rude to the resident. Resident #017 reported the incident to S #115 the morning after the incident occurred. The incident was not reported to the Director until six days later. During an interview, the DOC confirmed that the incident was not reported until six days later. [s. 24. (1)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #017 was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

Resident #017 reported to S #115 that one evening, S #114 treated the resident in an inappropriate manner and was rude to the resident. The resident reported that the staff member turned off their television while they were watching it, using both remotes, making it impossible for the resident to turn on their television in the morning.

During an interview, resident #017 confirmed to the inspector that S #114 was rude to them.[s. 3. (1) 1.]

2. The licensee failed to ensure that resident #010's rights were fully respected and promoted and that the resident was protected from abuse.

According to a CI, upon entering the home, the DOC overheard S #110 yelling at resident #010. S #110 was observed to be yelling at the resident and conducting themselves in an inappropriate manner. The DOC removed S #110 from their duties.

The inspector spoke with S #107 regarding the incident. S #107 indicated that S #110 was verbally inappropriate towards resident #010. S #107 confirmed that S #110 did not complete the home's abuse and neglect training in 2014.

Inspector #543 spoke with the DOC regarding the incident that occurred. The DOC confirmed that they witnessed S #110 speak inappropriately to resident #010.

Inspector #543 reviewed the home's Resident Abuse policy (P.P.P. 02-061) which stated that the home is committed to provide competent and compassionate care to its residents. The home has a zero tolerance philosophy in regards to resident abuse and all staff would be trained annually on the policy and are subject to annual retraining of their respective mandatory education. Verbal abuse is defined in this policy as any form of communication which demonstrated disrespect towards the resident including but not limited to name calling, shouting and an inappropriate tone of voice and manner of speaking which is upsetting and/or frightening for the resident. [s. 3. (1) 2.]

3. The licensee failed to ensure that resident #014's rights were fully respected and promoted and that this resident was not neglected by staff.

Inspector #543 reviewed a CI regarding alleged staff to resident abuse/neglect that occurred in 2015. The CI indicated that resident #014 reported to two staff members that they did not want to receive care from a certain staff member because that staff member had told the resident not to ring their call bell, therefore this resident was afraid to use their call bell for fear of getting in trouble.

The inspector reviewed documentation related to the above incident which described that a staff member told the resident that they would not provide them with care and that they would have to wait until the next shift staff came on. The resident also stated that the staff member told them to stop using their call bell and that they were not going to help them to bed.

Inspector interviewed S #107 regarding the alleged abuse/neglect. S #107 confirmed that the above mentioned allegation occurred and that resident #014 stated they were afraid to ring their call bell for assistance for fear of getting in trouble.

The inspector reviewed documentation which stated that the investigation initiated in regard to the CI related to the allegation of staff to resident abuse/neglect concluded that the behaviour was construed as negligence and resulted in disciplinary action. [s. 3. (1) 3.]

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 ensuring that residents are treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, that residents are protected from abuse and that residents are not neglected by staff, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Falls Prevention and Management policy was complied with.

During stage 1 of the RQI, S #115 indicated that resident #008 sustained a fall. Upon reviewing resident #008's health care record, Inspector #543 identified that there was no documentation pertaining to the fall.

The inspector interviewed S #106 regarding resident #008's fall and S #106 confirmed that there were no notes in Gold Care indicating that resident #008 had a fall and no post fall assessment or internal incident form was filled out. S #106 indicated that after every fall, the RNs are to fill out an internal critical incident report and that a post fall assessment should be completed.

Inspector #543 interviewed S #105 regarding resident #008's fall. S #105 confirmed that the resident did have a fall, however there were no notes in Gold Care indicating that the resident had a fall.

During an interview, S #104 confirmed that the resident had a fall, that an internal critical incident form should have been completed and confirmed that there was no documentation in the resident's health care record related to the fall.

Inspector #543 reviewed the home's Falls Prevention and Management policy last revised May 7, 2015, specifically related to post fall management. The policy indicated that when a resident has fallen, the resident would be assessed regarding the nature of the fall and the associated consequences as well as the cause of the fall and the post fall management needs. The responsibilities of the RN included, but were not limited to entering each fall in the "scheduled event" section of the Gold Care Program, as per instructed on the post fall investigation summary report. The policy further indicated that nursing staff who have the most knowledge of the fall are to complete a detailed progress note of the incident. [s. 8. (1) (a),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 ensuring that the falls prevention and management policy is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During the inspection, resident #015 explained to Inspector #575 that they had advised the home of the disrepair of their room approximately two years ago and that to date, nothing had been repaired. Inspector #575 observed the resident's wood closet door was rough at the bottom and the wall beside the resident's bed had peeling paint and gouges in the wall. In addition, the inspector observed a hole in the wall behind the main door into the resident's room that appeared to be caused by the door handle.

Inspector #575 interviewed S #112 about the home's process for maintaining a good state of repair within the home. S #112 indicated that once every six months they conduct an inspection of all resident rooms to identify areas that need to be repaired and create a list of areas that need attention. The list is then given to the maintenance staff to complete the repairs where needed. S #112 indicated that painting or drywall repairs

should be completed within two months from the inspection. In addition, when a resident is discharged or transfers rooms, the maintenance staff will complete repairs in that room including nicks, holes, flooring, etc. Repairs are completed on a weekly basis with most painting and crack filling completed on the weekends. S #112 indicated that resident #015 and approximately three other residents' closet doors needed to be 're-skinned'. S #112 indicated they were not aware of the state of the resident #015's walls.

The inspector requested a copy of the audit inspection conducted in February 2015. The audit indicated that in resident #015's room 'one wall bottom repair patch' and 'closet door to be repaired or changed'.

Inspector #594 conducted a tour of the home on September 25, 2015. The following were observations recorded:

Section B

* Outside B12 dry wall plaster not painted
* B15 main door horizontal scratches from door handle down
* B18 bathroom door scratched, drywall corners damaged
* B8 Bathroom door with a hole

1st Floor

* Wall in Chatelaine room - beside paper towel dispenser/fridge: paint scratched off in horizontal line exposing bare drywall, doors leading to courtyard - bottom dirty, floor tile chipped at entrance (from hallway) exposing dirt and debris accumulation
* Wall under Chatelaine's bulletin board scratched with black marks, paint chipped exposing drywall
* Library – lower plastic trim peeling away from wall, radiator – black marks
* Wall across from hair dressing room on main floor: hole in drywall, floor trim pulling away and in one area pushed into wall exposing broken drywall
* Wall outside hair dresser: Wall scratched
* Across from tv lounge, under nursing station window - Wall scratched
* Rm 170, 168, 167, 166 wall damaged outside of rooms exposing drywall
* Walls along 1st floor corridor scratched with black marks, 163A stairway door wall scratched
* Hole in wall outside Rm 164
* Rm 161 door corner scratched

* Rm 158 – wall corner at floor missing plastic protective corner, broken off
* Outside soiled utility room, floor trim pulled away from wall
* 1st floor dining room wall under nursing station pass through drywall damaged under hand sanitizer, wall damaged under electrical plug near water dispenser/fridge
* Holes in wall behind rocking chair across from elevators behind kitchen window pass through on 1st floor
* Walls consistently scratched along both resident room hallways

2nd floor

* Dining room wall damaged under nursing station pass through, corners near table 11 and the two large pillars damaged, white paint over green wall paint at corner by kitchen fridge in dining room
* Rm 207, 233-janitor, 215, 220, 219 – door missing protective layer at bottom exposing dried glue/substance
* Rm 209 - wall corner at floor missing plastic protective corner, broken off, exposing drywall screws
* Rm 213 holes in wall outside door (~3cmx2cm)
* Outside Rm 214: small hole with large paint chipped area exposing drywall
* Radiator along window at end of hall, dented, rust streaks and paint missing, paint scratched along wall
* Wall damaged (drywall pushed in) outside Rm 218
* Paint scratched outside Rm 221

3rd floor

* Dining room wall damaged under nursing station pass through, corners near table 11 and the two large pillars damaged
* Wall scratched beside table 11 (between 11 and 10) and supporting wall beside table 7
* Walls consistently scratched along both resident room hallways
* Rm 309, 316 - door missing protective layer at bottom exposing dried glue/substance
* Radiator along window at end of hall, dented, rust streaks and paint missing, paint scratched along wall
* Wall damaged (drywall pushed in) across from Rm 321

During an interview, S #112 indicated that resident #015's room was planned to be repaired during the following week of the inspection.

Many areas of the home as outlined were damaged and not 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 ensuring that the home is maintained in a safe condition and in good state of repair, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Resident Abuse policy (P.P.P. 02-061) was complied with.

According to a CI, upon entering the home, the DOC overheard S #110 yelling at resident #010. S #110 was observed to be yelling at the resident and conducting themselves in an inappropriate manner.

The inspector spoke with S #107 regarding the incident. S #107 indicated that S #110 was verbally inappropriate towards resident #010. S #107 confirmed that S #110 did not complete the home's abuse and neglect training in 2014.

Inspector #543 spoke with the DOC regarding the incident that occurred. The DOC confirmed that they witnessed S #110 speak inappropriately to resident #010.

Inspector #543 reviewed the home's Resident Abuse policy (P.P.P. 02-061) which stated that the home is committed to provide competent and compassionate care to its residents. The home has a zero tolerance philosophy in regards to resident abuse and all staff would be trained annually on the policy and are subject to annual retraining of their respective mandatory education. Verbal abuse is defined in this policy as any form of communication which demonstrated disrespect towards the resident including but not limited to name calling, shouting and an inappropriate tone of voice and manner of speaking which is upsetting and/or frightening for the resident. [s. 20. (1)]

2. The licensee has failed to ensure that the home's Resident Abuse policy (P.P.P. 02-061) was complied with.

Inspector #543 reviewed a CI regarding alleged staff to resident abuse/neglect that occurred in 2015. The CI indicated that resident #014 reported that they did not want to receive care from a certain staff member because that staff member had told the resident not to ring their call bell, therefore this resident was afraid to use their call bell for fear of getting in trouble.

The inspector reviewed documentation related to the above incident which described that a staff member told the resident that they would not provide them with care and that they would have to wait until the next shift staff came on. The resident also stated that the staff member told them to stop using their call bell and that they were not going to help them to bed. Further documentation revealed that an investigation was initiated and the home found that the staff member's behaviour was negligent and resulted in disciplinary action.

Inspector interviewed S #107 regarding the alleged abuse/neglect. S #107 confirmed that the above mentioned allegation occurred and that resident #014 stated they were afraid to ring their call bell for assistance for fear of getting in trouble.

Inspector #543 reviewed the home's Resident Abuse policy (P.P.P. 02-061) which stated that the home is committed to provide competent and compassionate care to its residents. The home has a zero tolerance philosophy in regards to resident abuse. In this policy, neglect is defined as the failure to provide the care and assistance required for the health, safety or well-being of a resident. [s. 20. (1)]

3. The licensee has failed to ensure that the home's Resident Abuse policy (P.P.P. 02-061) was complied with.

Inspector #575 reviewed a CI regarding an alleged staff to resident abuse. The CI indicated that resident #017 reported to S #115 that one evening, S #114 treated the resident in an inappropriate manner and was rude to the resident. Resident #017 reported the incident to an RPN the morning after the incident and a progress note indicated that the RPN reported the incident to an RN.

During an interview, the DOC reported that if an allegation is brought forward to the RN they are to verify what occurred, advise the DOC, and call the Ministry to report the incident to the Director. The DOC indicated that the investigation did not begin until six days later when they became aware of the allegation and the incident was not reported to the Director until that time (six days later).

Inspector #543 reviewed the home's Resident Abuse policy (P.P.P. 02-061) which indicated that the home would immediately investigate all incidents of alleged, suspected or witnessed abuse. [s. 20. (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 ensuring that the Resident Abuse policy (P.P.P. 02-061)is complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

s. 31. (4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's staffing plan included a back-up plan for personal care staffing that addressed situations when staff cannot come to work.

Inspector #543 reviewed the home's staffing plan and identified that the plan did not include a back-up plan for personal care staffing that addressed situations when staff cannot come to work.

During an interview, Inspector #543 asked the Administrator if the home had a written back-up plan for staffing when units are short staff members and they are not able to replace sick calls. The Administrator verified with the DOC, who indicated that there was nothing in writing, but that staff know that duties are to be divided accordingly.

On September 25, 2015, the inspector spoke with the DOC regarding the home's policy titled Staffing Plan for Nursing Staff Shortages, specifically related to a back-up plan for personal care staffing that addressed situations when staff cannot come to work. The DOC indicated that the home distributed tasks amongst staff members and at times they would pull the PSW scheduled as the "float" to the unit that was short and prioritize the tasks that needed to be completed. The DOC confirmed that there was nothing in writing to identify these plans. [s. 31. (3)]

2. The licensee has failed to ensure that there was a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

Inspector #543 interviewed the DOC regarding the annual evaluation of the home's staffing plan and if there was a written record relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. The DOC indicated that they have only reviewed their staffing plan on one occasion and that they did not have a written record of the review. [s. 31. (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 ensuring that the staffing plan includes a back-up plan for personal care staffing that addresses situations when staff cannot come to work and that there is a written record of each annual evaluation of the staffing plan including the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #8: 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: 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).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On September 16, 2015 in one of the dining areas and on September 23, 2015 in another dining area, Inspector #543 observed the lunch meal service and identified that

the staff were serving the residents their desserts before the main course was completed and prior to any dirty dishes being removed from the residents' tables.

On September 24, 2015, Inspector #594 observed the lunch meal service another dining room. The inspector observed that desserts were being served while residents were still eating their main course.

On September 24, 2015 the inspector spoke with S #125 regarding the dining service process. S #125 indicated that the tables needed to be cleared in between courses, for example, main course dishes must be removed prior to serving dessert.

Inspector #543 reviewed the home's policy titled Pleasurable Dining which indicated that the residents would be served course by course and soiled dishes would be removed between each course. [s. 73. (1) 8.]

2. The licensee has failed to ensure that the home has a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During the inspection, an evening meal service was observed. Inspector #594 observed S #129 standing over a resident seated in their wheelchair, assisting them with eating.

The inspector reviewed the home’s policy titled Dietary Services Manual Nutrition Pleasurable Dining #05-01-29 that indicated when staff are providing assistance to a resident during their meal, staff are to sit and maintain eye contact with the resident. [s. 73. (1) 10.]

3. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

During a lunch meal service, Inspector #594 observed one staff member assisting a total of four residents with feeding. The inspector reviewed the residents’ care plans related to eating, which indicated for each resident that they required total assistance of one staff. In an interview with the inspector, S #132 confirmed that all four residents required assistance with feeding.

Inspector #543 reviewed the home's policy titled Pleasurable Dining which indicated that staff would promote an engaging, un-rushed atmosphere and reduce disruptive situations

in the dining room. This policy indicated that staff could feed a maximum of two residents requiring total assistance. [s. 73. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs and that staff members assist only one or two residents at the same time who need total assistance with eating or drinking, to be implemented voluntarily.

WN #9: 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 has failed to ensure that all staff 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.

Inspector interviewed S #130 regarding mandatory training provided to staff in the home. The mandatory training included but is not limited to Residents' Bill of Rights, Policy for Zero Tolerance for Abuse and Neglect, Fall Prevention and Management Program and Infection Prevention and Control: Hand Hygiene. S #130 confirmed that not all staff completed the mandatory training for the year 2014. Inspector #543 reviewed the home's training records for 2014 and identified that 13/170 staff employed in the home did not complete the training as required. [s. 76. (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 ensuring that all staff receive retraining annually in the areas mentioned under subsection (2), to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record kept of the annual Infection Prevention and Control program evaluation that included the following:
* the date of the evaluation
* the names of the persons who participated
* a summary of the changes made, and
* the date those changes were implemented.

On September 24, 2015, Inspector #575 interviewed S #113 regarding the Infection Prevention and Control program (IPAC). S #113 indicated that the IPAC program policy was evaluated in 2014, however, there was no written record of the evaluation or any changes that have been made. [s. 229. (2) (e)]

2. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

Inspector #543 observed several dining services, and observed the following infection control concerns:

On September 14, 2015, during the lunch service in one of the home areas, hand hygiene was not being performed. The inspector observed a staff member take food temperatures, prepare the servery, and prepared food without washing their hands prior to serving the food. The dietary aide was observed to leave the serving area, then returned and started serving food without performing hand hygiene. During this same meal service, a staff member was observed assisting one resident to eat, then left the table to assist another resident, and then came back to the table to assist the first resident, and did not perform hand hygiene between residents. Another staff member was observed assisting a resident with feeding, then left the table to perform other tasks. When the staff member returned to assist the resident, no hand hygiene was performed.

On September 16, 2015, during the lunch service in one of the home areas, a staff member was observed to use the thermometer in all foods being served without wiping it clean between each temperature. The staff member was also observed to prepare food without performing hand hygiene.

On September 23, 2015, during the dinner meal service in one of the home areas, a staff member placed bowls of salad on a cart and left the cart unattended in the entry to the dining room. Several residents, staff and family members were observed in and out of the entry to the dining room, passing by this cart with uncovered food. The bowls of salad on the cart, were then brought out to the dining room and served to the residents. During the same dinner service, a staff member was observed serving plated food to residents with gloves on, then they proceeded to remove dirty plates from tables, performed hand hygiene with their gloves on, and then went about serving food to residents.

Inspector #543 spoke with S #125 regarding the dining service expectations. S #125 indicated that hand hygiene should be performed upon arrival to the dining room, in between tasks such as clearing dirty plates and serving food. At no time are staff members who wear gloves to perform hand hygiene with their gloves on. S #125 also confirmed that serving carts with food on them are not to be left unattended and that the expectation was to load the carts with the plated food just prior to serving them to the residents. [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 ensuring that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval, and contact information for the Director.

Inspector #575 reviewed a complaint related to the refusal of admission for client #019. The complainant claimed the home refused admission due to the staff lacking expertise in certain care areas and the home could not safely meet the client's needs and ensure other residents' safety due to the resident's diagnoses.

A staff member at the Community Care Access Centre (CCAC), provided the inspector with the date of the initial application.

The inspector reviewed the refusal letter written by the home. The letter indicated that the home would be withholding admission because staff lacked the nursing expertise in in certain care areas, that the decision was based on the information received from CCAC and that they could not meet the needs of the client due to the client's diagnoses and certain behaviours. The letter did not provide for a detailed explanation of the supporting facts as they relate both to the home and to the applicant's condition and requirements for care, an explanation of how the supporting facts justify the decision to withhold approval, and contact information for the Director. [s. 44. (9)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Resident #018 reported to S #117 that S #118 had injured the resident while providing care. The resident was upset and stated they did not want S #118 to care for them. An investigation into the allegation commenced immediately, however the home's internal incident report filed by S #117 indicated that the resident's SDM was not notified until 27.5 hrs after the alleged abuse was reported. [s. 97. (1) (b)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

In a report submitted to the Director on May 12, 2015, it was documented that a disease outbreak was declared by the Public Health Unit on May 05, 2015. In an interview with Inspector #594, the DOC stated that they have the responsibility of submitting reports to the Director and was unsure why the report was submitted seven days after the outbreak was declared. [s. 107. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to keep a written record, that is promptly prepared of:

* The monthly analysis, the annual evaluation and the changes and improvements required;
* the date of the annual evaluation;
* the names of the persons who participated in the evaluation; and
* the date that the changes were implemented.

Inspector #575 interviewed S #107 regarding the monthly analysis of the restraining of residents. S #107 indicated that on average, the use of restraints is reviewed more than once per month, however, there is no record in writing of the monthly analysis. [s. 113. (e)]

WN #15: 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 drugs are stored in an area that is used exclusively for drugs and drug-related supplies.

Inspector #594 and Inspector #543 observed medicated creams for two residents in an office supply drawer at one of the nursing stations. In an interview with Inspector #594, S #122 stated the medicated creams were not to be stored in the drawer and should have been given to the registered nursing staff to store in the medication room.

The inspector reviewed the home's Drug Storage policy #D-030 and the Pharmacy Medication Storage policy #3.2 which documented that all drugs/biomedical and medication shall be stored in a secure fashion in medication rooms and or medication carts and must be kept locked at all times. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate locked area within the locked medication cart.

During a medication pass observed by Inspector #594, the inspector observed S #131 store numerous residents' controlled medications in the first drawer of the medication cart that also contained residents' other medications. This drawer locks when the medication

cart is locked.

The inspector reviewed the home's policy titled Medication Storage Narcotic Storage #N-008 approved June 2008 and reviewed May 2011, which indicated that active storage: regular dosing and actively used controlled drugs prescribed as needed (PRN), would be in the locked narcotic boxes within each locked medication cart. The home's medication storage of medication policy #S-060 approved August 2011 and reviewed June 2013, indicated that narcotics were separated from and stored within a separate locked box within the locked medication cart (no narcotics are to be left unattended. Single locked and keys left in the cart key hole is considered unattended). Narcotics/controlled drugs must always be stored within a double locked system. According to the same document, non-carded narcotics are to be stored in the locked narcotic drawer within the locked medication cart. The home's pharmacy medication storage in the facility policy #6.0 revised August 2013 documented that narcotic and controlled substances shall be stored in a separate locked area within the locked medication cart. The home's pharmacy narcotic and controlled medications policy #6.2 revised August 2013 documented that any narcotic and controlled medication shall be stored in the narcotic box contained on the locked medication cart.

In an interview with the inspector, the DOC stated that the expectation is that narcotics and controlled substances are stored in the locked narcotic box in the medication cart and staff are not to store all resident narcotics in the first drawer of the medication cart. [s. 129. (1) (b)]

Issued on this 3rd day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDSAY DYRDA (575), MONIKA GRAY (594), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2015_332575_0017
Log No. / Registre no:	021569-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 30, 2015
Licensee / Titulaire de permis :	THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST 100 Michaud Street, STURGEON FALLS, ON, P2B-2Z4
LTC Home / Foyer de SLD :	AU CHATEAU 100 MICHAUD STREET, STURGEON FALLS, ON, P2B-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JACQUES DUPUIS

To THE BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING WEST, 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)

Linked to Existing Order / Lien vers ordre existant: 2015_282543_0008, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care, is provided to residents #003, #001, #008 and to all residents as specified in their plans of care.

This plan is to include but not be limited to: ensuring that all staff are trained in the home's policy to minimize the restraining of residents and that staff who apply physical devices or who monitor residents restrained by physical devices or PASDs are trained in the application, use and potential dangers of these physical devices and/or PASDs.

This plan shall also ensure that an analysis of the restraining of residents by use of a physical device is undertaken on a monthly basis. In addition, this plan shall include how the licensee will ensure that fall prevention interventions included in the plans of care are implemented

This plan may be submitted in writing to Lindsay Dyrda, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, by email: lindsay.dyrda@ontario.ca, or by fax: 705-564-3133. This plan must be received by December 11, 2015 and fully implemented by January 1, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care, was provided to resident #003 as specified in the plan.

On three occasions, Inspector #575 observed resident #003 in their wheelchair with a device applied. The inspector reviewed the resident's plan of care which indicated that the resident had the device used as a restraint. Upon further review, the documentation identified an additional intervention, to be implemented daily. The inspector reviewed the documentation for a period of approximately 21 days regarding this intervention and noted that during that period, it was only implemented on one occasion.

During an interview, S #119 indicated that the item to be used for the intervention was not always available, therefore the resident did not always have it.

S #116 confirmed that the intervention was not provided to the resident as ordered.
(575)

2. The licensee has failed to ensure that the care set out in the plan of care, was provided to resident #001 as specified in the plan.

On five occasions throughout the inspection, Inspector #575 observed resident #001 in their wheelchair with a device applied.

The inspector interviewed S #102 regarding the device. S #102 indicated that the device was used at all times when the resident was up in their chair. S #102 further indicated that the device was used to help the resident during meal time and the staff used it for positioning. S #102 indicated that the resident was dependent on staff for care and that S #102 reviewed the type of care to provide to the resident by reviewing the resident's care plan.

During an interview, S #103 indicated that the resident's device was not a restraint, that the resident would not be able to remove the device, and that it was used for positioning and for assisting with feeding the resident. S #103 was not able to find the use of the device in the resident's care plan.

During an interview, S #107 indicated that the use of the device should be in the resident's care plan. S #107 indicated that if it was not in the care plan, then staff should not apply it. S #107 confirmed to the inspector that the use of the device was not in the resident's plan of care. (575)

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #008 as specified in the plan.

During stage 1 of the Resident Quality Inspection (RQI), S #115 indicated that resident #008 sustained a fall in 2015. The inspector reviewed the home's internal incident report filled out four days after the fall, which indicated that the resident attempted to get up on their own and sat on the floor next to their bed. This incident report identified that the resident was barefoot at the time of the fall.

Inspector #543 reviewed the resident's most recent care plan, specifically related to falls and/or mobility, which indicated that this resident required antislip slippers when in bed. The incident report indicated that the resident was not wearing their antislip slippers when in bed, therefore the care was not provided as planned.

During an inspection completed November 2014, under inspection #2014_282543_0027, a previous compliance order (CO) was issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) 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.

During a follow-up inspection completed April 2015, under inspection #2015_282543_0008, a CO was re-issued pursuant to the LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) 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, and was linked to the previous existing CO.

The decision to issue this compliance order was based on the scope which involved three residents and the severity which resulted in actual harm for one resident and potential for actual harm for two residents. Despite previous non-compliance (NC), NC continues with this area of the legislation.
(543)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

Specifically, the licensee shall re-educate all staff on the reporting requirements under s. 24(1) of the LTCHA and develop and implement a process to ensure that all allegations of abuse are reported immediately.

Grounds / Motifs :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #575 reviewed a CI regarding an allegation of staff to resident abuse. The CI indicated that resident #017 accused S #114 of treating the resident in an inappropriate manner and was rude to the resident. Resident #017 reported the incident to S #115 the morning after the incident occurred. The incident was not reported to the Director until six days later. During an interview, the DOC confirmed that the incident was not reported until six days later. (575)

2. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director:

Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Inspector #575 reviewed a CI regarding an allegation of staff to resident abuse. The CI indicated that resident #018 accused S #118 of injuring them while providing the resident care. The accusation was reported to S #117, however the incident was not reported to the Director until two days later.

During an interview, the DOC confirmed that the incident was not reported to the Director until two days after the allegation was brought forward. (575)

3. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #543 reviewed a critical incident (CI) regarding alleged staff to resident abuse/neglect that occurred in 2015. The CI indicated that resident #014 reported that they did not want to receive care from a certain staff member because that staff member had told the resident not to ring their call bell, therefore this resident was afraid to use their call bell for fear of getting in trouble.

The inspector reviewed documentation related to the above incident which

described that a staff member told the resident that they would not provide them with care and that they would have to wait until the next shift staff came on. The resident also stated that the staff member told them to stop using their call bell and that they were not going to help them to bed.

Further documentation revealed that an investigation was initiated and the home found that the staff member's behaviour was negligent and resulted in disciplinary action. The CI indicated the date that the incident occurred, however the incident was not reported to the Director until approximately 36 hours later.

The decision to issue this compliance order was based on the scope which involved three separate critical incidents and the severity which indicated actual harm. Despite three previous non-compliance (NC), issued as Voluntary Plans of Correction, NC continues with this area of the legislation.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 01, 2016

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 30th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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