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 prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 15, 2017;	2017_668543_0005 (A1)	015736-17	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE PARRY SOUND ON P2A 2A2

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance order compliance due date extension requested and approved until January 31, 2018.

Issued on this 15 day of December 2017 (A1)

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

Original report signed by the inspector.

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 14-18, 2017 and August 21-25, 2017.

The following intakes were inspected during this Resident Quality Inspection (RQI):

One follow-up related to CO #001 from inspection report #2017-638609-0010 related to Plan Of Care s. 6 (7);

One complaint submitted to the Director related to resident elopement, and two complaints related to Plan of Care;

Six Critical Incident reports that were submitted to the Director related to Responsive Behaviours;

Four Critical Incident reports that were submitted to the Director related to Falls;

One Critical Incident report that was submitted to the Director related to Reporting;

One Critical Incident report that was submitted to the Director related to alleged Abuse.

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, directly observed various meal services, reviewed resident health care records, reviewed staffing patterns and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Administration (DONA), Associate Director of Resident Care (ADORC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager (FSM), Dietary Staff, residents and their families.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Food Quality

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

- **7 WN(s)**
- **3 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. 6. (7)	CO #001	2017_638609_0010	642

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. 72. Medical Director

Specifically failed to comply with the following:

s. 72. (1) Every licensee of a long-term care home shall ensure that the home has a Medical Director. 2007, c. 8, s. 72. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a Medical Director.

According to O. Reg.79/10, s. 214 (3), and for the purposes of clause 72 (3) (b) of the Act, the Medical Director has the following responsibilities and duties:

1. Development, implementation, monitoring and evaluation of medical services.
2. Advising on clinical policies and procedures, where appropriate.
3. Communication of expectations to attending physicians and registered nurses in the extended class.
4. Addressing issues relating to resident care, after-hours coverage and on-call coverage.
5. Participation in interdisciplinary committees and quality improvement activities.

Inspector #543 reviewed documentation dated May 2015, identifying that the home had accepted the Medical Director's resignation.

In an interview with the Administrator and the DONA, on August 17, 2017, they indicated that the home had been without a Medical Director since 2015. The Administrator indicated that some advertising had been done (by the previous Administrator), prior to them assuming the position of Administrator in January 2017. During the interview, they verified that there was nobody; at this time who was assuming the duties provided for in O. Reg., 214 (3). [s. 72. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee has failed to ensure that the home's "Falls Prevention & Management Policy", was complied with.

A Critical Incident (CI) report was submitted to the Director in October 2016, which indicated that resident #010 sustained a fall on a specific date in October 2016, whereby the resident was found on the floor. The CI report also identified that the resident's fall intervention device was not functioning properly.

Inspector #638 reviewed resident #010's health care records and identified that the care plan in effect at the time of the fall in October 2016, indicated that the resident had specific interventions in place related to their "Risk of Injury from Falls" foci.

The home's policy titled "Falls Prevention & management Policy - NR G 533" effective date July 2014, indicated the PSWs were expected to follow the interventions as outlined in the care plan. Another specific policy (used in

conjunction with the Falls Program) effective date October 2012, indicated that the PSW was responsible for checking devices, in use by residents assigned to them, at the beginning and end of their shift, to ensure the devices were in good working order.

In an interview with Inspector #638, PSW #104 indicated that their role in fall prevention was to ensure that the interventions were implemented as per the resident's plan of care. The PSW indicated that whenever a resident had a specific intervention in place, that it would be checked at the beginning of each shift and whenever it was being used.

Inspector #638 interviewed PSW #130, who indicated that whenever a resident required this specific intervention, they were required to assess the intervention was functioning at the beginning of the shift.

The Inspector reviewed a specific report for the resident's room on specific dates in October 2016, which indicated that the resident's fall intervention device was not functioning properly on those dates.

In an interview with Inspector #638, the ADOC indicated that PSWs were required to check the functionality of the intevention at the beginning of their shift. The ADOC indicated that at times, staff do not accurately verify the functionality of specific interventions. Upon reviewing the home's policy with the ADOC, they indicated that based on a specific report it was evident that the functionality of the intervention was not checked on the shift the resident fell. [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 to ensure that specific home policies are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had their personal items labelled within 48 hours of admission and of acquiring new items.

During the initial tour on August 14, 2017, Inspector #638 identified two used nail clippers in one of the tub rooms, which were not labelled and one electric razor used and unlabelled in the shower room. Inspector #638 brought PSW #104 to observe these personal items, who then stated that resident personal items were supposed to be labelled and kept in their resident specific bins. The PSW indicated that if they found items that were used and not labelled, they would dispose of them.

Inspector #638 also identified during the initial tour on August 14, 2017, on another home area, that there were two pairs of used and unlabelled nail clippers and six bottles of shampoo left out on the counter in the tub room which were unlabelled and used. The Inspector observed these items with PSW #103 who indicated that only the home's products would not be resident specific, however, these shampoo bottles were residents' personal items. The PSW indicated that all personal items should be labelled and if they were unsure of whom they belonged to, they would

be thrown out.

On August 16, 2017, Inspector #543 observed two nail clippers, styling mousse and hand soap in a shared resident bathroom. The Inspector identified Vaseline cream, Ivory body wash, a hairbrush and denture brush in the shared bathroom for two specific rooms, each item was used and not labelled. Furthermore, the Inspector identified "Pond's" cream, Purell and a hairbrush in another shared bathroom.

Inspector #638 observed on August 15, 2017, one used electric razor which was not labelled in another shared bathroom.

In an interview with Inspector #638, RN #101 indicated that all resident personal items were supposed to be labelled and kept in the resident specific storage bins. The RN indicated that the resident's personal items were on a cleaning schedule which would include labelling items as required.

Inspector #638 reviewed a memo sent to "Nursing Staff" on April 27, 2017, which indicated that during an audit they had identified combs and unlabelled personal hygiene products. It was identified that there were "several" used nail clippers left out in the tub room.

During an interview with Inspector #638, the ADOC indicated that all resident's personal items should be labelled and that they periodically brought a PSW in to ensure that all items were labelled. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home has their personal items labelled within 48 hours of admission and of acquiring new items, to be implemented voluntarily.

WN #4: 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 were stored in an area that was used exclusively for drugs and drug-related supplies.

Inspector #543 observed on August 16, 2017, one medicated cream belonging to resident #017 in a room. The Inspector also identified resident #016 had a medicated cream at their bedside and a tube of medicated ointment was identified at the bedside of resident #015.

Inspector #638 reviewed a memo sent to "Nursing Staff" on April 27, 2017, which indicated that during an audit of the tub rooms and dining rooms, medicated shampoos were located in the tub rooms.

In an interview with Inspector #638, RPN #127 indicated that PSWs were able to administer medicated ointments on residents once they were certified by a registered staff member. The RPN indicated that after the medicated ointment was applied, the PSWs were expected to return the medicated ointment to the registered staff for storage in the medication cart.

The home's policy titled "Medications - Security and Accountability - NR G 502" effective May 2014, indicated that the registered staff of the home area would maintain and control access to medications, prescriptions and non prescription drugs. The policy also indicated that the registered staff would secure all medications in accordance with MOHLTC guidelines.

In an interview with Inspector #638, the ADOC indicated that the storage of all medications including medicated ointments were to be kept in the medication carts. The ADOC indicated that this was an ongoing concern. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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, clear directions to staff and others who provide direct care to

the resident.

A complaint was submitted to the Director in April 2017, which indicated that some of resident #009's care needs were not being met. The complaint alleged that the resident was not being provided assistance with specific ADLs.

Inspector #638 reviewed resident #009's health care record and identified within their care plan two interventions related to specific ADLs. The first intervention located under the "CCL Assistance" foci, identified specific interventions for the resident. While the second intervention located under the "ADL Assistance" foci, also identified specific interventions related to the resident's needs.

In an interview with Inspector #638, PSW #118 and PSW #128 indicated that resident #009 required assistance with specific ADLs throughout the day. The Inspector reviewed the resident's current care plan with PSW #128 who indicated that the "CCL Assistance" intervention was no longer in effect, could have caused confusion and "probably" should have been removed from the care plan once the new intervention was initiated.

Inspector #638 interviewed RPN #112 who indicated that whenever a resident's needs changed, their care plan should be updated in entirety by registered staff as to not cause confusion and identify the resident's changes.

In an interview with Inspector #638, the ADOC indicated that resident #009's care plan was not clear and could have caused confusion related to assisting the resident's with their ADL needs. The ADOC indicated that when the care plan was updated, the staff could have missed the previous intervention which was located under another foci of their care plan. The ADOC indicated that they believed the intervention located under the "ADL" foci was the most recent one, however, it could have caused confusion. [s. 6. (1) (c)]

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

On August 15 and 22, 2017, Inspector #543 observed resident #003 seated in a chair with an assistive device applied.

Inspector #543 reviewed this resident's care plan, specifically related to assistive devices which indicated that resident #003 had a risk for falls, and that the resident

required a specific assistive device.

The Inspector observed resident #003 on August 15, 18 and 22, 2017, during each observation the resident was seated in a chair with an assistive device applied.

Inspector #543 reviewed this resident's health care record, and was not able to locate appropriate documentation related to the assistive device. Upon further review of the health care record, there was no assessment forms completed identifying the need for the assistive device.

In an interview with RN #129, they verified that the appropriate documentation related to the assistive device was not completed. RN #129 verified that resident #003’s care plan did not identify the need for the device.

Inspector #543 interviewed RPN #123 who stated that resident #003 required an assitive device. They verified that any resident who required an assistive device, would be assessed for the device and the device would be included in their care plan.

Inspector #543 interviewed PSW #122 who stated that resident #003 had an assistive device, however it should be reassessed as the resident may no longer need it.

Inspector #543 interviewed the DONA, who indicated that a resident who may require an assistive device must be assessed for the need of the device, proper documentation must be obtained from the resident or the SDM. They verified that the device must be included in their plan of care, clearly indicating the need, the type of device and the purpose for the device. [s. 6. (2)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

A complaint was submitted to the Director. The complaint identified resident care and personal hygiene concerns for resident #009. During an interview with Inspector #638, the complainant identified that the resident was not receiving adequate oral hygiene as per their needs.

Inspector #638 reviewed resident #009’s health care records and identified in their care plan under the ADL foci, that the resident required extensive assistance for

personal hygiene and one staff member to encourage or provide assistance to the resident to brush their teeth and clean their dentures.

The Inspector reviewed the "Belvedere Daily Care Flow Sheets" for resident #009 between July and August 2017. Upon review the Inspector identified multiple gaps in the documentation record related to a specific ADL.

The resident's documentation was incomplete or partially incomplete on 18 out of the 43 days reviewed (41 per cent of the time).

In an interview with Inspector #638, PSW #118 indicated that all care provided to residents was documented on the PSW flow sheets. Upon reviewing the "Belvedere Daily Care Flow Sheets" for resident #009 with the PSW, they indicated that the documentation should have been filled out in entirety.

During an interview with Inspector #638, RPN #111 indicated that the PSWs document their care on the flow sheets. The Inspector reviewed the flow sheets with the RPN who indicated that the care was probably provided and just not signed, however, they should have completed the documentation.

The home's policy titled "Resident Care Plan Protocol - NR G 502" effective July 2017, indicated that the registered staff would ensure that the provision and outcomes of the care set out in the care plan was documented.

In an interview with Inspector #638, the ADOC indicated that PSWs were required to document all care completed in their flow sheets and if staff were having difficulty completing their documentation, they would have been allotted additional time to ensure the completion of the documentation. Upon reviewing resident #009's "Belvedere Daily Care Flow Sheets", the ADOC indicated that the documentation regarding the resident's oral care should be completed in entirety to demonstrate the care provided to the resident. [s. 6. (9) 1.]

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

Resident #001 was identified as having impaired skin integrity from their April, 2017, Minimum Data Set (MDS) assessment.

Inspector #638 reviewed resident #001's health care records and identified a "Wound Assessment", which indicated that the resident had previous impaired skin integrity that had resolved. The Inspector reviewed the eTAR for resident #001 which identified that the resident's skin care interventions had been discontinued by RPN #113 on a specific date in August 2017.

In a review of resident #001's care plan, Inspector #638 noted that the resident was identified as having impaired skin integrity.

In an interview with Inspector #638, RPN #111 on August 17, 2017, indicated that resident #001 did not currently have impaired skin integrity. The RPN stated that the resident's skin integrity issues were an ongoing issue.

During an interview with Inspector #638, RPN #112 (Wound Care Nurse) indicated that resident #001 had ongoing impaired skin integrity, however, whenever impaired skin integrity was resolved registered staff should remove it from the resident's care plan.

The home's policy titled "Resident Care Plan Protocol - NR G 502" effective date July 2017, indicated that the RN or RPN would ensure the resident is reassessed and the care plan was reviewed and revised when the resident's care needs changed and when the care set out in the plan was no longer necessary.

In an interview with Inspector #638, the DONA indicated that whenever impaired skin integrity was resolved, the registered staff would complete an assessment, update the eTAR to discontinue to treatment and update the care plan. The DONA indicated that resident #001's care plan should have been updated when the resident's impaired skin integrity had resolved. [s. 6. (10) (b)]

5. Resident #006 was identified as having worsening behaviours from their June, 2017, MDS assessment. Inspector #638 reviewed the MDS assessment for resident #006 and identified that the resident had an increase in their responsive behaviours in comparison to their previous MDS assessment.

Inspector #638 reviewed resident #006's "Belvedere Daily Care Flow Sheets" between July and August 2017. The flow sheets identified that resident #006 had responsive behaviours on seven out of 31 days (22.5 per cent of the days) in July and 11 out of 20 days (55 per cent of the days) in August. On average the resident

demonstrated responsive behaviours 35 per cent of the days during the review period.

In an interview with Inspector #638, PSW #110 indicated that resident #006 had responsive behaviours, however was unsure of the specific of type of responsive behaviours. Direct care staff refer to the resident's printed care plan and kardex for resident specific information and interventions.

Inspector #638 conducted an interview with PSW #118 who indicated that staff would refer to the resident's care plan for resident specific responsive behaviours or interventions. The PSW stated that they were aware that the resident had responsive behaviours, however, had never experienced resident #006 being responsive and indicated that the specific behaviour should be identified in the care plan.

During an interview with Inspector #638, RN #117 stated that direct care staff refer to the resident's care plan when reviewing resident specific behaviours, triggers and interventions. The Inspector reviewed resident #006's "Belvedere Daily Care Flow Sheets" with RN #117 who indicated that their care plan should identify specific responsive behaviours due to the frequency of their behaviours.

In an interview with Inspector #638, the RAI Coordinator indicated that whenever a MDS assessment was completed, the results were sent to the assigned registered staff member to review and update the care plan as needed. The RAI Coordinator indicated that resident #006's assessed responsive behaviours should have been included in their care plan.

The home's policy titled "Resident Care Plan Protocol - NR G 502" effective date July 2017, indicated that the plan of care was based on the resident's mood and behaviour patterns, which included any identified responsive behaviour.

In an interview with Inspector #638, the DONA indicated that resident specific responsive behaviours should be documented within their care plan as this was what the direct care staff referred to for their care needs and interventions. The Inspector reviewed resident #006's MDS assessment with the DONA, which indicated that the resident had demonstrated responsive behaviours during the assessment period. The DONA stated that responsive behaviours should have been included in resident #006's care plan. [s. 6. (10) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist a resident with a routine activity of daily living was consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Through observations resident #003 was observed with an assistive device while up in a chair.

Inspector #543 reviewed this resident's care plan, specifically related to assistive devices which indicated that resident #003 had a risk for falls, and that the resident required an assistive device.

The Inspector observed resident #003 on August 15, 18 and 22, 2017, during each observation the resident has an assistive device applied.

Inspector #543 reviewed this resident's health care record, and was not able to locate proper documentation related to the assistive device.

Inspector #543 interviewed RN #129 who verified that the use of an assistive device required proper documentation and an assessment completed. They substantiated that there was no documentation in resident #003's health care record related to the assistive device

Inspector #543 interviewed the DONA, who indicated that a resident who may require a assistive device must be assessed for the need of the device, that documentation must be obtained from the resident or SDM. [s. 33. (4) 4.]

WN #7: 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):
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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act., followed by the report required under subsection (4).

A CI report was submitted to the Director on a specific day in June 2017. According to the CI report an acute respiratory illness outbreak was declared in June 2017.

Inspector #543 reviewed the documentation (Outbreak Summary Report) from the home, which indicated that the Health Unit was informed of the outbreak on a specific day in June 2017, and declared over in July 2017.

Inspector #543 reviewed the home's "Infection Prevention and Control Subsection: Outbreak Management" policy (IPC:M 10.00), with a revision date of March 2017. The policy indicated that if determined by the Public Health Unit to be a confirmed outbreak the DONA/ADRC/Designate will notify the MOHLTC Compliance advisor and complete and submit a Critical Incident Report.

Inspector #543 interviewed the Administrator who stated that they were aware that the outbreak that was declared in June 2017, and was not reported to the Director on time. They indicated that the DONA had previously made them aware of the late reporting. [s. 107. (1) 5.]

Issued on this 15 day of December 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543) - (A1)

Inspection No. / No de l'inspection : 2017_668543_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 015736-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Dec 15, 2017;(A1)

Licensee / Titulaire de permis :
BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2

LTC Home / Foyer de SLD :
BELVEDERE HEIGHTS
21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2

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

Ministère 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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Marsha Rivers

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To BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND 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)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 72. (1) Every licensee of a long-term care home shall ensure that the home has a Medical Director. 2007, c. 8, s. 72. (1).

Order / Ordre :

The licensee shall develop, submit and implement a plan that includes a detailed description of how the licensee will ensure that the home recruits a Medical
Director, including what process they will use to ensure compliance related to all aspects of clause 72 (3) (b) of the Act, and s. 214 (3) of the O. Reg. 79/10.

This plan shall be submitted in writing to Tiffany Boucher, Long-Term Care Homes Inspector at 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5. Alternatively, the plan may be faxed to the Inspector's attention at (705) 564-3133.

The plan must be submitted by November 8 , 2017, and fully implemented by December 15, 2017.

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that the home had a Medical Director.

According to O. Reg.79/10, s. 214 (3), and for the purposes of clause 72 (3) (b) of the Act, the Medical Director has the following responsibilities and duties:

1. Development, implementation, monitoring and evaluation of medical services.
2. Advising on clinical policies and procedures, where appropriate.
3. Communication of expectations to attending physicians and registered nurses in the extended class.
4. Addressing issues relating to resident care, after-hours coverage and on-call coverage.
5. Participation in interdisciplinary committees and quality improvement activities.

Inspector #543 reviewed documentation dated May 2015, identifying that the home had accepted the Medical Director's resignation.

In an interview with the Administrator and the DONA, on August 17, 2017, they indicated that the home had been without a Medical Director since 2015. The Administrator indicated that some advertising had been done (by the previous Administrator), prior to them assuming the position of Administrator in January 2017. During the interview, they verified that there was nobody; at this time who was assuming the duties provided for in O. Reg., 214 (3). [s. 72. (1)] (543)

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

Jan 31, 2018(A1)

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, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

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

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15 day of December 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TIFFANY BOUCHER - (A1)

Ontario

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Service Area Office / Bureau régional de services : Sudbury