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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 19, 2013	2013_246196_0002	S-000080-13	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7

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

BETHAMMI NURSING HOME
63 CARRIE STREET, THUNDER BAY, ON, P7A-4J2

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 4, 2013

Inspection report # 2013_104196_0007 was issued to the Licensee and Administrator on September 4, 2013. The data was re-entered into the IQS program on September 19, 2013 under new inspection # 2013_246196_0002

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Clinical Manager, Registered Nursing staff, Personal Support Workers (PSW), RAI Coordinator, Dietary staff members, Registered Dietitian (RD), Residents

During the course of the inspection, the inspector(s) conducted a walk through tour of all resident home areas, observed the provision of care and services to residents, observed the interactions between staff members and residents, reviewed the health care records of several residents.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

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. A Critical Incident report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on March 2013 outlining the circumstances in which resident #001 was transferred to hospital as a result of an incident that had occurred in the home. The report provides the details of the resident assessment and the staff member's interventions and subsequent transfer to hospital.
The care plan that was in effect at the time of the incident was reviewed by the inspector and had identified risk relating to choking. It had interventions aimed at reducing this risk, including supervision by staff members and a minced diet.
Interviews were conducted with staff members during the inspection and it was consistently reported that resident #001 was at risk relating to choking. An interview was conducted with staff member #102 and it was reported that the type of supervision that was being provided to resident #001 was to watch and reorient them and that feeding the resident was intermittent, the staff would sit and feed them, but not every day nor every meal.
According to staff member #105, resident #001 had, in the past, taken food off of the plate of the resident seated beside him and this resident was on a regular diet. The Critical Incident report noted that it is not known how resident #001 ate food that had not been provided specifically for them, as it was not observed by staff.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

2. On April 4, 2013, the inspector observed resident #005 sitting in a wheelchair with a front closing seat belt in place across the waist. According to staff member #100, the resident is unable to cognitively remove the seat belt but can physically undo it. This was confirmed when resident #005 was asked to remove the seat belt and did not understand the request and was unable to remove it. An interview was conducted with staff member #101 on April 4, 2013, and it was reported that the seat belt is put on every time the resident is seated in the wheelchair. The health care record for resident #005 was reviewed and included a physician's order for "safety – front facing seat belt for resident safety" and the treatment administration record (TAR) included the intervention of "Safety – front facing seat belt for resident safety" prn. The care plan included under the focus of "locomotion on unit r/t safety" the intervention of "when in w/c apply seat belt for safety- (resident #005) can undo on own" and under the focus of falls/balance there is the intervention of "ensure seat belt is fasten when in wheelchair for safety and staff to document and monitor use". In the same current care plan there is also the focus of "Restraints r/t seat belt that (they) can unfasten

and rails" and has the intervention of "seat belt to fasten for (their) safety and body alignment". The resident is no longer able to cognitively open the seat belt as was determined by the inspector and staff member #100, and therefore the seat belt is considered a restraint. The plan of care for resident #005 was not reviewed and revised to reflect this change in care needs.

The licensee failed to 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, (b) the resident's care needs change or care set out in the plan is no longer necessary; [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the care set out in the plan of care is provided to residents as specified in their plans and ensures that resident #005 is 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 change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. Resident #004 was identified by staff as using a restraint. The health care record was reviewed and included a physician's order for the use of a "Restraint – rear closing seat belt on w/c" and a written consent from the POA was located in the resident's chart.
The inspector reviewed the treatment administration record (TAR) for March and April 2013 and noted the intervention of "Restraint - rear closing seat belt on w/c". The section for the registered staff to initial on the TAR, identifying that they had reassessed the resident at least every eight hours, was blank in over forty spaces.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

WN #3: 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. During the inspection, a resident care cart was observed in the hallway outside a resident room, containing a plastic bin with prescription topical medications for several residents.
Inside the bin, there was a container of cream for resident #002, a container for resident #003 and a container for resident #004. The plastic bin was on top of the care cart and within access of anyone and there were no staff members observed in the area.

The licensee failed to ensure that, (a) drugs are stored in an area or a medication cart, (ii) that is secure and locked [s. 129. (1) (a) (ii)]

Issued on this 20th day of September, 2013

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