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
Feb 26, 2015	2014_269597_0004	S-000431-14	Resident Quality Inspection

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

BEVERLEY GELLERT (597), DEBBIE WARPULA (577), GILLIAN CHAMBERLIN (593)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 6 -17, 2014

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Nursing Manager, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN)

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
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
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. 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: 9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. 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,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has a dining and snack service that includes, at a minimum, the following elements: review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Inspector #577 interviewed Resident #019 and it was reported that the Residents' Council does not review meal and snack times. It was reported by #S-126 that the Residents' Council had an opportunity to review meal times about 10 years ago and but they are unsure if snack times were reviewed at that time.

Inspector #577 interviewed #S-112 on October 17, 2014. #S-112 reported that Residents' Council meetings and Food Committee Meetings are considered separate but have been scheduled together for 5 years. #S-112 reported that the times for meals and

snacks have not been reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee has failed to provide personal assistance to residents requiring assistance at meals to ensure that the resident is able to eat and drink safely and as comfortably as possible.

A complaint was submitted to the Ministry of Health and Long-Term Care in relation to not enough staff available to provide assistance to residents at meal times in a dining room within the home.

During a lunch service in the home, Inspector #593 observed the family member of one resident providing feeding assistance to another resident. No staff were observed to provide assistance to this resident during the lunch period. The plate belonging to this resident was cleared away by staff with more than 50% of their meal remaining. It was also observed this resident was not offered dessert during this meal period.

During a lunch service in the home, one resident asked Inspector #593 if they could place a sandwich triangle in another resident's hand. Inspector #593 informed a PSW of this request who then provided the sandwich. Inspector #593 observed that the sandwich had been sitting in front of this resident for 25 minutes without any assistance provided by staff. There was no further assistance provided by staff and 75% of the sandwich remained at the end of the meal. It was also observed that this same resident was not offered dessert during this meal.

During a lunch service in the home, Inspector #593 observed the family member of one resident provide feeding assistance to another resident. Staff were not observed to provide assistance to this resident during the lunch period and approximately 75% of their meal was remaining when the plate was cleared away by staff.

During a dinner service in the home, Inspector #593 observed a meal provided to a resident at 1737 hrs. Assistance was not provided by staff to this resident until 15 minutes after the meal was initially placed in front of them. During an interview with staff, it was confirmed that this resident requires assistance at all meals.

Two other staff members reported to the inspector that this resident requires assistance at all meals. They also reported that the resident is able to finish 75% of a meal but only if assistance by staff is being provided.

Both staff reported that there is not enough staff available to feed all residents requiring assistance and therefore residents have to wait. They also added that the food often gets cold and they have to reheat meals in the microwave before serving.

Inspector #593 interviewed a family member who reported that the staff will sometimes place food in front of one of the residents and if the resident does not know that the food is there, they have observed staff in the home, clear the plates away from the resident before the resident has eaten any of the meal.

Inspector #593 reviewed this resident's plan of care which indicated that staff are to provide extensive assistance at all meals and throughout the whole meal. Staff are also required to provide direction and assistance with eating, as the resident will stop eating if they are having difficulty with eating. [s. 73. (1) 9.]

3. The licensee has failed to use proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

During a lunch service in the home, Inspector #577 observed one resident leaning towards their left side and trying to hold their plate for 30 minutes. Inspector #577 inquired to a PSW about the positioning of this resident who then placed a pillow behind the resident's back and began to assist them.

During a dinner service in the home, Inspector #593 observed #S-124 provide feeding assistance to a resident, #S-124 was standing next to the resident while feeding the resident.

During a dinner service in the home, Inspector #593 observed #S-114 seated on a high stool between two residents. #S-114 was observed to be seated approximately 2 feet above eye level for one resident and approximately 1.5 feet above eye level for the other resident while providing feeding assistance to both residents.

Inspector #593 interviewed #S-114 who reported that they have not attended education on safe feeding in the home and they reported that safe feeding included ensuring that staff are seated next to the resident and facing them.

Inspector #593 interviewed #S-117 who reported that they have not attended education on safe feeding in the home. #S-117 reported that they have to remain standing while feeding so that they can move quickly between residents. [s.73(1)10]

4. The licensee has failed to serve meals to residents requiring assistance only when assistance is available.

A complaint was submitted to the Ministry of Health and Long-Term Care in relation to not enough staff to provide assistance to residents at meal times in the home.

During a lunch service in the home, a resident asked the inspector if they could place a sandwich triangle in another resident's hand. Inspector #593 informed a PSW of this request who then placed a sandwich triangle in hand of the resident. Inspector #593 observed that the sandwich had been sitting in front of the resident for 25 minutes without any assistance provided by staff. The resident finished the triangle sandwich and no further assistance was provided by staff to finish the remaining sandwich, 75% of the sandwich remained at the end of the meal. It was also observed that the resident was not offered dessert during this meal.

During a dinner service in the home, Inspector #593 observed that a meal provided to a resident at 1737 hrs. Assistance was not provided by staff until 15 minutes after the meal was initially placed in front of them.

Inspector #593 interviewed #S-114, who reported that this resident requires full feeding assistance at all meals and that the resident is able to finish 75% of a meal when full assistance by staff is being provided.

#S-114 reported that there is not enough staff available to feed all residents requiring assistance and therefore residents have to wait. They also added that the food often gets cold and they have to reheat meals in the microwave before serving.

During a lunch service in the home, Inspector #593 observed a family member of one resident provide feeding assistance to another resident.

Inspector #593 interviewed #S-123, who reported that a family member of a certain resident will often assist in feeding other residents, they further advised that this is acceptable to the home.

Inspector #593 interviewed #S-112. #S-112 reported that they are not aware of any family members feeding other residents and this is not acceptable unless the other resident or SDM has agreed to this, that it is documented and the Registered Dietitian

has spoken with the family member providing the assistance regarding dietary requirements and other aspects of the resident's care.

A review of this residents plan of care found no documentation relating to being assisted at meals by another resident's family member. [r.73. (2) (b)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

It was identified during a family interview, that a resident had dental problems. Inspector #577 reviewed the resident's health care record and could not find a documented dental assessment. Inspector interviewed #S-101, and it was reported that the home does not offer annual dental assessments to residents.

Inspector #577 interviewed the Nursing Manager and the DOC, and it was reported that the home does not offer annual dental assessments to all residents. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to provide an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required to Resident #013 and any other resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident is

assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Resident #002 suffered a fall with no injury in 2014. Inspector #577 reviewed the progress notes which indicated that resident had an unwitnessed fall in their bathroom and was found by staff lying on the floor.

Inspector #577 interviewed #S-123, regarding documentation responsibilities post resident fall. #S-123 reported that they document in the following places; progress notes, electronic incident/safety report, paper post fall assessment and electronic "Full Assessment" specific to falls.

The inspector interviewed #S-102, who reported staff may be unclear about whether to use a paper or electronic form for a post fall assessment. The inspector #577 also interviewed the Nursing Manager who confirmed that an electronic post-fall assessment is done by staff after a fall. The Nursing Manager was unable to find a completed electronic post fall assessment on for this resident.

Inspector #577 interviewed #S-116, who reported that an electronic post-fall assessment should be completed after a fall and they confirmed that a post fall assessment was not completed post fall for this resident.

Resident #014 suffered a fall with no injury in 2014. Inspector #577 reviewed the progress notes which indicated that the resident had an unwitnessed fall in their resident room. The resident was assessed and transferred back to bed without injuries. Progress notes indicated that resident suffered an second unwitnessed fall without injury approximately one month later.

Inspector #577 interviewed #S-124 and #S-125 about documentation post falls. Both staff reported that after a resident fall, they will document electronically in a progress note and electronic incident report but do not fill out a paper or electronic post fall assessment. It was reported they only document fall assessments quarterly.

Resident #013 suffered a fall with an injury in 2014. Inspector #577 interviewed #S-116, and it was reported that an electronic post-fall assessment should be done after a fall and #S-116 confirmed that a post fall assessment was not completed post fall for Resident #013.

Resident #018 suffered a fall with an injury in 2014. Inspector #577 interviewed #S-102, who reported that staff may be unclear about whether to use a paper or electronic form for a post fall assessment. The Nursing Manager was unable to find a completed electronic post fall assessment for Resident #018.

Inspector #577 interviewed #S-116, and who reported that an electronic post-fall assessment should be completed after a fall and confirmed that a post fall assessment was not completed post fall for Resident #018.

Resident #003 suffered a fall with an injury in 2014. Inspector #577 interviewed #S-116, who reported that an electronic post-fall assessment should be done after a fall. #S-116 reported that a post fall assessments was not completed post fall for Resident #003. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls for Residents #002, #003, #013, #014, #018 and all other residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with weight changes of 10% or more over a six month period are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated.

A review of Resident #003's weight records by Inspector #593 indicated that the resident had a significant weight loss over a six month period.

Inspector #593 interviewed #S-112, who reported that for residents with significant weight changes; they will communicate these with the home's Registered Dietitian (RD) and the RD will undertake a nutritional assessment of the resident as soon as possible. They further reported that both themselves and the RD will regularly review weights to look for significant changes that have been flagged in the system.

Inspector #593 reviewed Resident #003's progress notes and found that, the significant weight loss was not addressed immediately by the home's RD.

A review of the resident's medication administration record by Inspector #593 found that no specific interventions to promote weight gain were charted for this resident.
[s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 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 that Resident #003 and all other residents with weight changes of 10% or more over a six month period are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to provide retraining on the home's policy to promote zero tolerance of abuse and neglect of residents at intervals provided for in the regulations.

Inspector #593 reviewed the home's education records for training on the "Prevention of Abuse and Neglect of Residents" policy which indicated that education during 2013 did not occur for staff in the home.

Inspector #593 interviewed #S-107, who reported that education and a tracking system for this did not commence in the home until 2014. #S-107 reported that prior to this, staff were required to read the home's abuse policy and sign off once this had been completed. A review of this sign off sheet found that less than 50% of staff had confirmed that they had read the home's abuse policy in 2013.

Inspector #593 interviewed the Administrator, who confirmed that the sign off sheets for reading the abuse policy were the only education records available related to the home's "Prevention of Abuse and Neglect of Residents" policy available for 2013.

A review of the home's policy LTC 5-50 "Zero Tolerance of Abuse and Neglect of Residents", dated January 2014, found that education pertaining to zero tolerance of abuse and neglect of residents is provided annually and on an as needed basis for employees, families and volunteers. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by provide retraining on the homes policy to promote zero tolerance of abuse and neglect of residents at intervals provided for in the regulation, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to 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).

It was observed by Inspector #577 that a Resident #016 was dressed only in their pyjamas until after lunch.

At 1256 hrs, Inspector observed #S-109 escort resident out of dining room to the hallway outside the tub room. The inspector inquired if it is usual practice to leave this resident dressed in their pyjamas in dining room until after lunch and it was reported by staff member that they do, and they did not have time to bath the resident this morning.

The Inspector reviewed the resident's care plan related to dressing, which indicated that staff are to provide total assistance with care.

Inspector #577 observed Resident #008 seated in their chair at a dining room table. The resident was not wearing any bottoms, except for a continence care product and their lower half was wrapped in a blanket.

Inspector #577 interviewed #S-129, who reported that the resident had clothes on their lower body earlier but they had spilled coffee, so the clothes had been removed. Inspector asked staff member if resident had clean clothes and the staff member reported that it was easier to wrap a blanket around the resident.[s. 3. (1) 1.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (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 provide clear direction to staff and others who provide direct care to the resident in the plan of care.

A review of Resident #013's current plan of care by Inspector #593 found that the resident is to have two top bed rails up at all time to assist with bed mobility and with transferring. In addition, the plan of care states that a full side rail is to be in the up position when the resident is in bed during sleep and rest for the resident's emotional comfort and security. The plan of care also designates that the top two bed rails are restraints and that both bed rails are to be up when in bed asleep at night for safety and protection.

Inspector #593 interviewed #S-116 on October 15, 2014, who reported that this resident requires two top rails up and that that the plan of care should have stated that the bed rails were PASD's and not restraints.

Inspector #593 interviewed #S-101, who reported that Resident #013's bed rails are for a feeling of security and comfort and that they are used for repositioning in bed. They do not consider the top two bed rails restraints as the resident can get in and out of bed on their own while they are in the up position.

Inspector #593 interviewed a PSW, who reported that the two top bed rails for Resident #013 are a feeling of security, as well as to assist with transferring and repositioning in bed. The PSW was not sure if they were considered restraints, however they believed they were not considered restraints as they were quarter rails. [s. 6. (1) (c)]

2. The licensee has failed to 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).

Inspector #577 made frequent observations during the inspection regarding the care of Resident #007. The inspector reviewed Residents #007's care plan related to toileting. The care plan indicated that the resident requires specific interventions related to toileting.

Inspector observed that the interventions were not carried out as stated in the care plan. It was reported by #S-111 that different interventions have been worked out with the resident's family member that are not recorded in the care plan.

On two occasions, Inspector #593 observed the top two quarter bed rails for Resident #013 were in the up position. The resident was observed to be asleep in bed at this time. The full side rail was not observed to be in the up position as stated in the plan of care while the resident was in bed during sleep and rest. [s. 6. (7)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Inspector #597 observed that a door leading to a secure outside area was unsupervised, unlocked and occasionally propped open. The signage posted by the home on the door indicated that the door must be locked at all times when the area was not in use.

Inspector #597 interviewed the DOC regarding the management of these doors. The DOC confirmed that the home does not have a formal policy regarding locking or unlocking of these doors.[s. 9. (2)]

WN #9: 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. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

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 there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

On October 16, 2014, Inspector #577 interviewed the DOC who reported that home does not have a formal written staffing plan. [s. 31. (2)]

2. The licensee has failed to ensure that the staffing plan must, (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 (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).

Inspector #577 interviewed the DOC who confirmed that the home does not have a staffing plan nor a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work. It was further reported that the evaluation and annual update is not complete. The DOC reported that their current staffing plan is in draft, not a formal guideline or written for specific scenarios. [s. 31. (3)]

The licensee has failed to ensure that 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).

Inspector #577 interviewed the DOC. It was reported that the home does not have a written record of each annual evaluation of the staffing plan. [s. 31. (4)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

During staff interviews it was noted by Inspector #597 that Resident #004 required a specific intervention to manage their continence care needs. The health care record of Resident #004 was reviewed and clinical evidence to support this intervention was not found.

Inspector #597 interviewed #S-102 regarding the reason for the specific intervention to manage the continence care needs of Resident #004. #S-102 reported that the resident had the intervention in place in the community before admission to home. #S-102 reported that they were not aware of a continence assessment being completed for Resident #004.

Inspector #597 interviewed #S-103 and #S-104 and they were not able to report a reason for the specific intervention to manage continence care needs for Resident #004.

Inspector #597 was unable to find a completed continence assessment in the health care record of Resident #004. [s. 51. (2) (a)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #577 interviewed Resident #019, who reported that the home does not respond in writing within 10 days of receiving Residents' Council concerns or recommendations. Resident #019 reported that there had been an ongoing concern reported to the licensee concerning a male resident who wanders into other resident rooms and takes things.

Inspector #577 interviewed the Administrator, related to Residents Council. They reported that they do not respond in writing within 10 days of receiving council advice about concerns or recommendations. They reported that they receive meeting minutes by email. [s. 57. (2)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

Inspector #597 interviewed two residents who reported a loss of personal property from their rooms in the last six months. The incidents were both reported to nursing staff.

Inspector #597 interviewed the DOC, regarding the procedure of managing complaints including lost or stolen property and they reported that the home does not practice a consistent method of complaint follow up.

Inspector #597 interviewed the Nursing Manager, regarding the procedure of managing

complaints including lost or stolen property. They reported that they would try to investigate and find out what happened by having discussions with resident, family and staff. The Nursing Manager reported that there isn't a formal policy or procedure in place to address these types of concerns and that any follow up provided to residents or families would be verbal.

Inspector #597 interviewed #S-101. They reported that if a resident reported loss of property, an electronic incident report would be completed. The incident reports are sent to the Nursing Manager for follow up.

Inspector #597 interviewed #S-102. #S-102 reported when PSWs report such an issue to them, they would speak with resident and family / SDM and verify concerns. They would try and reassure the resident, so they aren't afraid. If need be #S-102 would report to Nursing Manager and document in the electronic record if required.

Inspector #597 interviewed #S-107 regarding complaints of missing or stolen property and they stated that they would look into it, get the details and then let the team know.

Inspector #597 interviewed #S-103 and #S-104, regarding the home's process to manage lost or stolen property. #S-103 and #S-104 reported that first they would look for whatever is lost and usually it can be found. If the item / items were not found they would report it verbally to the registered staff, who will then report to the Nursing Manager. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

Inspector #597 interviewed the Nursing Manager, regarding the procedure of managing complaints including lost or stolen property. They reported that they would try and investigate and find out what happened by having discussions with resident, family and

staff. There could be notes entered in the electronic record by staff but they are not sure. The Nursing Manager reported that there isn't a formal policy or procedure in place to address these types of concerns and that any follow up provided to residents or families would be verbal.

Inspector #597 interviewed the DOC, regarding the procedure of managing complaints including lost or stolen property and they reported that documentation may or may not be recorded in the electronic record, but it is difficult to find. The home does not practice a consistent method of complaint follow up.

The Service Complaint policy and procedure # AD-133 and # AD-134 that was provided to the inspector and reviewed with DOC. The DOC reported that this policy / procedure has not been used to consistently address lost or stolen property.[s. 101. (2)]

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).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
   i. a breakdown or failure of the security system,
   ii. a breakdown of major equipment or a system in the home,
   iii. a loss of essential services, or
   iv. flooding.
   O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

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 an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

An disease outbreak at the home was declared on April 29, 2014 by Public Health, yet the Director was not notified until May 9, 2014.

A disease outbreak at the home was declared on August 8, 2014 by Public Health, yet the Director was not notified until August 12, 2014.

Inspector #597 observed a copy of posted information regarding immediate reporting of critical incidents and process of contacting management at the nursing station on the third floor. Item #8 identified that an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act required immediate reporting.

Inspector #597 interviewed the DOC and they confirmed that staff are aware of the posting. Staff are required to contact management and that management would notify the Director. Management names and numbers are listed on posting at the nursing station. Registered Staff will notify management if they have concerns after hours.

DOC confirmed that the above outbreaks were not immediately reported and states incident reporting site is difficult to use. [s. 107. (1)]

2. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Inspector #597 reviewed the progress notes for Resident #005 who suffered an unwitnessed fall with an injury in 2014, which resulted in a significant change to their health condition and was transferred to hospital.

A Critical Incident Report was received by the MOH 14 days after the injury occurred. [s. 107. (3)]

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

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Issued on this 27th day of February, 2015

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

#597

Beverley Gellert

Original report signed by the inspector.