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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 27, 2015	2015_333577_0016	026480-15	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

DEBBIE WARPULA (577), GILLIAN CHAMBERLIN (593), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 5, 6, 7, 8, 9, 13, 14, 15, 16, 2015

During the course of the inspection, the inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed the health care records for several residents, and reviewed numerous policies, procedures and programs.

The following log's were inspected concurrently with the RQI: #01770-15, #10048-15, #03962-15, #12560-15, #12561-15, #00022-15, #12559-15, #21957-15, #21968-15 and #21971-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), RAI Coordinator, Registered Dietitian(RD), Maintenance staff, Staffing Coordinator, Manager Employee Relations, Dietary staff, Registered Nurses(RN), Registered Practical Nurses(RPN), Personal Support Workers(PSW), Family Members and Residents

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Sufficient Staffing
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **11 VPC(s)**
- **3 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
O.Reg 79/10 s. 53. (4)	CO #001	2014_380593_0016	577
O.Reg 79/10 s. 73. (1)	CO #001	2014_269597_0004	577
O.Reg 79/10 s. 73. (2)	CO #002	2014_269597_0004	577

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #015 was protected from abuse by anyone.

On October 7, 2015, resident #015 reported to Inspector #196 that a staff member had abused them
but they could not recall their name or when it had occurred.

Inspector #196 conducted an interview with a family member of resident #015 and they reported that a series of emails outlining care concerns and alleged harm had been forwarded to the previous Clinical Manager in May 2015, regarding PSW #106. Specifically, in April 2015, resident #015 was crying and hurt while being transferred by the PSW. The family member indicated to the Inspector that they had asked the PSW to stop the transfer but they had continued. Another incident was witnessed by a different family member in May 2015, which resulted in a skin injury to resident #015 when the PSW provided care. The emails were reviewed by Inspector #196 and included expressed concern about resident #015's health, safety and risk for harm when the PSW was providing their care and not listening to the resident's requests or following their direction. The family member also reported that the resident was afraid of the PSW, and this staff member was no longer assigned to provide their care and ignored the resident and themself when they were in the dining room.

An interview with the DOC and the Manager of Employee Relations revealed that the PSW has been employed by the licensee, working in the role of Personal Support Worker since June 2014, not currently enrolled in an educational program for registered practical nurses, does not have the title of Registered Practical Nurse (RPN) and does not have a certificate as a PSW. In addition, the DOC reported that the PSW did not have mandatory education on zero tolerance of abuse and neglect of residents.

On October 15, 2015, Inspector conducted a telephone interview with the previous Clinical Manager which revealed that they did not report or forward this complaint to the

Director at the MOHLTC. They reported that they did not believe it was abuse towards resident #015. Furthermore, they stated that they felt it was a communication problem.

During an interview with the current DOC, on October 15, 2015, there were no other investigation notes regarding the family complaint about care except for hand writing on the printed copies of the emails.

An interview conducted with the current DOC and the Staffing Coordinator on October 14, 2015, determined that neither were made aware that the PSW was not to provide care to resident #015.

PSW #106 provided care to resident #015 that resulted in harm to the resident. The PSW did not have a PSW certificate, was not registered as a practical nurse and did not have training in the prevention of abuse and neglect of residents.

Non-compliance have been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 19.(1)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm and the compliance history which despite previous non-compliance (NC)issued including one compliance order, NC has continued with this area of the legislation. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the alleged or suspected abuse of resident #015 was investigated.

On October 7, 2015, resident #015 reported to Inspector #196 that a staff member had abused them but they could not recall their name or when it had occurred.

An interview was conducted with a family member of resident #015 and they reported to the Inspector that a series of emails that expressed concern and alleged harm had been sent to the previous Clinical Manager in May 2015, regarding PSW #106. The emails expressed concern about resident #015's health, safety and risk for harm when the PSW was providing their care and not listening to the resident's requests or following direction. The family member also reported that the resident was afraid of the PSW, and this staff member was no longer assigned to provide their care and ignored the resident and themself when they were in the dining room.

On October 15, 2015, Inspector spoke with the previous Clinical Manager regarding the email concerns that the home had received from resident #015's family member concerning the PSW. They reported that they did not report or forward this complaint to the Director at the MOHLTC, as they did not believe that it was abuse toward resident #015. Furthermore, they stated that they felt it was a communication problem and that staff were bullying the PSW. They also reported that the PSW was told they were no longer to provide care to resident #015, as per the family members request. The Clinical

Manager indicated that their investigation of the concerns included a discussion with the PSW regarding improper transfer of resident #015, not following policy for transfers and discussion of potential harm to resident #015. Inspector spoke with the current DOC and it was identified that there were no records of an investigation other than a few hand written notes on copies of the emails from the family member of resident #015.

Inspector #196 reviewed the licensee policy #LTC 5-70 titled "Complaints Management Program" with approval date of March 2015. Under 'Responsibility of Manager' it read:
-Investigates all verbal and written complaints and provide a response to the complainant within the time frame described above. Records are maintained, utilizing the "Internal Complaint Documentation Form(s)" part 1 and 2.
-Reports to the Ministry of Health and Long-Term Care all written complaints received".

Non-compliance had been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O 2007, s. 23.(1)(a)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates minimal harm or potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC has continued with this area of the legislation. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to report alleged abuse of resident #015.

On May 3, 2015, a family member of resident #015 forwarded an email to the previous Clinical Manager, concerning alleged harm to resident #015 by PSW #106.

On October 15, 2015, Inspector spoke with the previous Clinical Manager, who reported that the email concerns forwarded from the family member of resident #015 were not reported to the Director at the MOHLTC, as they did not believe that it was abuse toward resident #015. Furthermore, they stated that they felt it was a communication problem.

Non-compliance had been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O 2007, s. 24.(1)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm/risk and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC has continued with this area of the legislation. [s. 24. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

On October 16, 2015, at 1140hr, the DOC and Inspector #196 noted the odour of cigarette smoke in the north side corridor on one of the home units. The RPN was with resident #030 in the shared washroom and it was identified that resident #030 had been smoking a cigarette in the shared washroom and had put the cigarette in the toilet bowl. Resident #034 was observed lying in bed in the same room. A sign on the outside of the resident room identified that no smoking was permitted due to a health treatment.

The health care records for resident #030 were reviewed, which included the care plan and progress notes related to smoking concerns. The progress notes identified an incident of smoking in the bathroom of the main floor of the home in May 2015, the smell of cigarette smoke in the resident's room in May 2015, resident was found smoking in the sunroom in shared resident room in October 2015, and the smell of fresh cigarette smoke in bathroom hallway in September 2015, after they came out of washroom. Under a nursing focus, interventions included strategies to monitor residents smoking. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, specifically in regards to resident #030, to be implemented voluntarily.

WN #5: 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).

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 resident #007 that set out clear directions to staff and others who provided direct care for the residents.

During an interview with Inspector #593 on October 5, 2015, resident #007 reported that

they had dental problems. They further reported that their dentures were lost and they are not sure if they are going to be replaced.

Resident #007 was observed multiple times during the inspection by Inspector #593, and the resident did not have dentures in place during any of these observations.

A review of resident #007's current care plan found that there was a dental problem listed related to dentures and that interventions listed included staff to soak dentures at night and return in the morning and ensure dentures fit well.

A review of resident #007's Minimum Data Set (MDS) by Inspector #593 found the MDS completed May 14, 2015, referenced that the resident had dentures however the most recent MDS completed August 14, 2015, documents no reference to dentures in this assessment.

During an interview with Inspector #593 October 14, 2015, S#109 reported that resident #007 had no teeth or dentures and as far as they were aware, they were admitted to the home without any teeth or dentures. They further reported that oral care included cleaning the mouth twice daily with toothettes and mouth wash.

During an interview with Inspector #593 on October 16, 2015, S#110 reported that resident #007 had no teeth or dentures and it had been this way since they were admitted to the home in May 2015. For oral care, the resident used a toothette and most of the time, they can complete this care themselves but sometimes the PSW needs to assist with this. S#110 further reported that the resident did have a bottom denture but they refuse to wear it. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #015 as specified in the plan.

Inspector #196 observed resident #015 lying in bed on October 7, 2015, at 1050hr and on October 14, 2015, at 1615hr with bed rails elevated. Above the bed was a picture of a bed with bed rails elevated.

The health care record for resident #015 was reviewed and the current care plan indicated that the resident required the use of bed rails.

An interview was conducted with S#108 on October 14, 2015, at 1608hr and they

reported that in order to determine which bed rails were to be used for a resident, they would look at the care plan and look above the bed and there should be a picture card which shows what was to be used. An interview was conducted with S#114 on October 15, 2015, at 1615hr and they reported that resident #015 required the use of bed rails when in bed. [s. 6. (7)]

3. The licensee has failed to ensure that resident #002 was reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan was no longer necessary.

Resident #002 was observed multiple times during the inspection by Inspector #593, and the resident was observed to require the use of a wheelchair and could not ambulate around the home without the assistance of staff. The resident was not observed in any other residents rooms during this inspection.

A review of resident #002's current care plan found that there was a nursing problem documented related to inappropriate social behaviour with interventions that included re-directing resident away from other resident rooms. A review of resident #002's care plan from one year prior found the same problem identified with the same interventions listed to manage this.

A review of resident #002's MDS by Inspector #593 found the MDS completed September 2014, documented wandering behaviour occurred daily and was not easily altered and the MDS completed September 2015, documented that wandering behaviour did not occur.

A review of resident #002's electronic progress notes over the past 12 months found one incident documented related to this resident wandering into other residents rooms, this incident occurred in October 2014.

During an interview with Inspector #593, October 14, 2015, S#111 reported that resident #002 has never had any wandering behaviours that they were aware of and there are definitely no concerns with this behaviour at present. They added that this resident was not able to walk and required a wheelchair to ambulate with staff assistance.

During an interview with Inspector #593, on October 15, 2015, S#112 reported that resident #002 had required the use of a wheelchair for at least one year and cannot ambulate on their own. They further added that there may have been one or two

occasions in the past when resident #002 would enter another resident's room and eat their food, however this was certainly not happening anymore.

During an interview with Inspector #593, on October 16, 2015, S#113 reported that there were no behaviours present related to wandering or entering other resident's rooms. They added that resident #002 required a wheelchair to ambulate with staff assistance to move around the home. The wandering behaviour was a problem when they would enter other resident's rooms however this behaviour had not been present for at least a year.

During an interview with Inspector #593 on October 16, 2015, the DOC reported that the process for updating care plans was that when the changes are coded in the MDS, they are then required to update the care plan to reflect these changes. They further added that this may have been missed for this resident when the change in behaviour was coded in MDS.

A review of the home's policy: #LTC 3-50 Responsive Behaviour Program dated May 2012, identified that the resident's individualized plan of care was reviewed and revised as necessary at least quarterly or with an assessed need for change. The current needs were determined through MDS/RAI outcome scales, and on-going assessment by the interprofessional team and documentation in the resident's health record. [s. 6. (10) (b)]

4. The licensee has failed to ensure that resident #012 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, resident's care needs change or care set out in the plan is no longer necessary.

On October 14, 2015, at 1020hr, resident #012's bed was observed by Inspector #196 with bed rails elevated. Resident reported that when they were in bed they should have bed rails elevated. The picture above the resident's bed illustrated that bed rails were to be elevated.

An interview was conducted with S#108 on October 14, 2015, and they reported that above the resident's bed there should be have a picture to indicate which side rails are to be elevated. An interview was conducted with S#114 on October 15, 2015, and they reported that resident #012 had bed rails elevated when in bed and there was a picture card above the bed for reference.

The current care plan was reviewed for information regarding the use of bed rails and it indicated under a nursing focus, the intervention of bed rails up when in bed. The

Medication Reconciliation Order Form from the pharmacy service provider, dated May 2015, also indicated bed rails and at the time of inspection these bed rails were no longer in use. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, specifically in regards to resident #007; and that the care set out in the plan of care is provided to the resident as specified in the plan, specifically in regards to resident #015; and that the resident 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, specifically in regards to residents #002 and #012, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

On May 14, 2015, information was received by the Ministry of Health and Long Term Care regarding a report that there was no Registered Nurse(RN) on duty in the home for the evening shift in April 2015. It was identified by the complainant that this happens occasionally.

On October 7, 2015, inspector #621 met with S#103 to review the RN shift schedules and the home's back-up plan for addressing situations when scheduled RN's were unable to come to work. S#103 provided inspector #621 with copies of the RN shift schedules for April 15-May 15, 2015 and August 15-September 15, 2015. S#103 provided a copy of a tracking sheet entitled "Action Plan: Staffing Plan for RN Coverage at Bethammi" which they reported that the home had been using since June 21, 2015, to track when there was no RN on duty in the home and they defaulted to their back-up plan. It was identified that on these dates, there was no RN on duty in the home:
-two shifts in April 2015
-one shift in June 2015
-two shifts in July 2015
-one shift in August 2015
-four shifts in September 2015
-two shifts in October 2015

On October 08, 2015, inspectors #621 and #196 met with the Administrator and asked for examples of an emergency when an RN was not available and consequently no RN was in the building. The Administrator reported that examples included RN's calling in sick. The Administrator reported that the home would exhaust all measures and then follow the process as reflected in the revised copy of the June 9, 2015, staffing plan which is also their back-up plan entitled "Staff Plan for SJCG Long Term Care Homes Bethammi (BNH) and Hogarth Riverview Manor (HRM)". Despite having a back up plan there were still multiple shifts found where an RN was not on duty in the home as required. [s. 8. (3)]

2. The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care worked in that capacity, he or she was not considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

On October 08, 2015, the Administrator reported to inspector #621 that the current and past Clinical Manager, which is the homes Director of Care (DOC) had worked as both

DOC and RN at the same time. They further confirmed that the form used by S#103 to track RN coverage contained details as to dates when no RN was in the building and the DOC served also as RN for the home. A copy of this report was reviewed, and it was identified that on these dates, there was no RN on duty in the home and the DOC worked as both DOC and RN:
-one shift in July 28 2015
-two shifts in September 2015

On October 08, 2015, inspector #621 met with the DOC who reported that at times they were on duty as the DOC and acted in the capacity of the RN. [s. 8. (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 to ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations; and to ensure that during the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations., to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 31. (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 they kept a written record relating to each evaluation that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

On October 8, 2015, inspector #621 and #196 met with the Administrator and reviewed a copy of the homes final approved staffing plan dated June 9, 2015, entitled " Staffing Plan for St.Joseph's Care Group (SJCG), Long Term Care Homes Bethammi (BNH)" and "Hogarth Riverview Manor (HRM)". When asked about whether the home had completed any annual reviews of the homes staffing plan, the Administrator reported that they didn't have any documented evidence to confirm any annual reviews of the staffing plan had been completed.

Inspector #621 showed the Administrator a copy of the annual staffing plan template from the Staffing Plan Manual which identified areas to complete including a date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. The Administrator reported that they didn't have any documented evidence to confirm any annual reviews of the staffing plan being completed and in follow up with the previous DOC, the Administrator confirmed later on October 8, 2015, to inspector #621 and #196 that although the former DOC reported to them that the home had done work on an annual staffing plan review and evaluation, the Administrator did not have a written record of this. [s. 31. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee keeps a written record relating to each evaluation 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, to be implemented voluntarily.

WN #8: 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 received oral care to maintain the integrity of the oral tissue that included 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.

On October 8, 2015, it was identified during a resident interview, that resident #009 had dental problems.

Inspector #577 interviewed the DOC on October 13, 2015, about the home offering an annual dental assessment. They reported that the home did not offer annual dental assessments to all residents, and if there were dental issues, staff would approach resident's family about having a dental hygienist assess. [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 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, specifically in regards to resident #009, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (4) The licensee shall cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title, a person who was required to be enrolled in a program described in clause (3) (c) or (d) if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired. O. Reg. 79/10, s. 47 (4).

Findings/Faits saillants :

1. The licensee shall cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title, a person who was required to be enrolled in a program described in clause (3) (c) or (d) if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired.

On October 6, 2015, during an interview, S#116 reported to Inspector #196 that they were in the process of getting their certificate as a PSW, that they had dropped out of the college RPN program in January 2014, and had been working part time as a PSW at Bethammi since that time.

An interview was conducted with the Administrator on October 8, 2015, and they confirmed that S#116 was hired to work as a PSW while they were in school to become a RPN, and that they did not have a PSW certificate nor were they a RPN.

S#116 was currently working in the home in the role of a Personal Support Worker, were no longer enrolled in a registered practical nursing program and they did not have a PSW certificate.

An interview was conducted with S#115 on October 14, 2015, in the presence of the DOC. S#115 provided the employee file for S#106 and reported that in the past, employees that had not been successful in their exams to register had been offered and put into a PSW position, without a certificate as a PSW.

Inspector #196 reviewed the employee file for S#106 and found that in May 2014, S#106 started at Bethammi Nursing Home in the position as a temporary full time Registered Practical Nurse in the Nursing Graduate Guarantee Program. An email between the Human Resources department and the staffing coordinator of the home, dated June 2014, identified that S#106 was in the RPN NGG program and they didn't pass their RPN exam. Due to staffing shortages, S#106 was transferred from the position of RPN/NGGP to part time position of PSW, effective June 2014.

S#106 has been employed by the licensee, working in the role as a Personal Support Worker since June 2014. S#106 was not currently enrolled in an educational program for registered practical nurses, did not have the title of Registered Practical Nurse (RPN) and did not have a certificate as a PSW. [s. 47. (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 to ensure to cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title, a person who was required to be enrolled in a program described in clause (3) (c) or (d) if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired, specifically in regards to S#106 and S#116, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's weights were measured and recorded on a monthly basis.

A review of the homes electronic weight records found that multiple residents did not have documented weights for one or more months over the past 12 months.

Inspector #593 reviewed the electronic weight records over the past 12 months and found a pattern of resident weights not being completed during this time period:

Resident #002- No weight completed in July or August 2015
Resident #004- No weight completed in April, July or August 2015
Resident #005- No weight completed in November and December 2014; January, July, August or September 2015
Resident #006- No weight completed in April, May or September 2015
Resident #031- No weight completed in February or August 2015
Resident #032- No weight completed in July, August or September 2015
Resident #033- No weight completed in September 2015

During an interview with Inspector #593 on October 13, 2015, the Registered Dietitian (RD) reported that the process for completing monthly weights was that the PSW's were to complete these for each resident on their bath days. They record the weight in a binder located in the tub room and then this information is transferred to the electronic record system. They further reported that there were often missing monthly weights and they had to ask for this to be completed so that they could finish their assessment.

During an interview with Inspector #593 on October 16, 2015, the DOC reported that they have yet to improve the process of documenting weights at the home by the PSWs. They added that the weights being recorded in the electronic system were used to flag any significant weight loss which was then referred to the RD for assessment.

A review of the home's policy: #LTC 5-10 Unintentional Weight Loss or Gain dated January 2013, identified that residents are weighed on the same scale, at the same time of day each month usually on bath day. Weights are recorded in the electronic record and regularly reviewed by the dietitian. [s. 68. (2) (e) (i)]

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 a weight monitoring system to measure and record with respect to each resident is done on admission and monthly thereafter, specifically in regards to residents #002, #004, #005, #006, #031, #032 and #033, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that the home has a dining and snack service that included course by course service of meals for each resident.

On October 5, 2015, at 1215hr, during the lunch meal service on one of the home units, Inspector #593 observed eight residents being served their entrée when they were still finishing their soup.

On October 5, 2015, at 1230hr, during the lunch meal service on the same home unit, Inspector #593 observed a dietary aide commence serving of desserts to residents in the dining room. 11 residents were observed to be finishing their entrée when they were served their dessert. Resident #010 was observed to be finishing their entree and soup and was observed to be eating all three courses at the same time. Resident #010's care plan did not identify the requirement for all courses to be served simultaneously.

On October 9, 2015, at 1209hr, during the lunch meal service on another home unit, Inspector #593 observed all residents in the dining room eating soup. While most

residents were still finishing their soup, it was observed that the entrées were served to the residents.

On October 9, 2015, at 1233hr, during the lunch meal service on the same home unit, Inspector #593 observed S#117 commence serving of desserts to all residents seated in the dining room. It was observed that 17 residents were still finishing their entrée when the dessert was served to them.

On October 14, 2015, at 1212hr, during the lunch meal service on another home unit, Inspector #593 observed staff begin to serve main meals to residents in the dining room. It was observed that six residents were still eating their soup when their entrée was served to them.

On October 14, 2015, at 1237hr, during the lunch meal service on the same home unit, Inspector #593 observed the Dietary Aide commence serving of desserts to all residents seated in the dining room. It was observed that 20 residents were still eating their entrée when the dessert was served to them. Resident #010 was observed to be eating their entrée and dessert at the same time.

On October 14, 2015, at 1800hr, during the dinner meal service on a home unit, Inspector #593 observed S#118 commence serving of desserts to all residents seated in the dining room. It was observed that 24 residents were still finishing their entrée when the dessert was served to them.

A review of the diet rosters located in the dining rooms on two home units, found no documentation related to any residents requiring or requesting multiple courses being served simultaneously.

During an interview with Inspector #593, October 15, 2015, S#123 reported that there had been some ongoing concerns regarding meal times and service of meals to residents. Their main concern was that not all residents are seated in the dining room at the start of the meal service and therefore the meal service was delayed, this may then have an effect on the service of meals course by course. They further added that the residents should not be served multiple courses at once as this did not promote pleasurable dining. [s. 73. (1) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, a course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs, specifically in regards to residents #010 and all residents on the second and third level of the home, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)

(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the required information was posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

During the initial tour of the home on October 5, 2015, the posting of the required information was not in a conspicuous and easily accessible location. The plastic holders that contained the required postings were unlabelled and placed high on the wall out of reach of anyone in a wheelchair. A walk through with the DOC was conducted and they confirmed to the inspector that residents in wheelchairs and with limited mobility would not be able to reach up high on the wall to obtain or read a copy of the posted information. [s. 79. (1)]

2. The licensee has failed to ensure that the required information for the long-term care home's procedure for initiating complaints to the licensee was posted.

During the initial tour of the home, on October 5, 2015, the home's procedure for initiating complaints to the licensee was not posted. A walk through the the resident care units was conducted with the DOC and they confirmed to the inspector that the home's procedure for making a complaint was not posted on either unit. [s. 79. (3) (e)]

3. The licensee has failed to ensure that the required information for notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained was posted.

During the initial tour of the home, on October 5, 2015, the home's notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy could be obtained was not posted for those that reside or frequent the third floor unit to access. A walk through of the resident care units was conducted with the DOC and they confirmed to the inspector that the third floor unit did not have a home's policy to minimize the restraining of residents nor a notification of how to receive a copy posted. [s. 79. (3) (g)]

4. The licensee has failed to ensure that the required information, copies of the inspection reports from the past two years for the long-term care home were posted.

During the initial tour of the home on October 5, 2015, all copies of inspection reports from the Ministry of Health and Long-Term Care (MOHLTC) from the last two years were not posted on either the second or third floor unit. One MOHLTC report dated February 28, 2014, was located in the plastic holders on both second and third floor units but not all reports from the last two years. [s. 79. (3) (k)]

5. The licensee has failed to ensure that the required information, orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years were posted.

During the initial walk through on October 5, 2015, the plastic holders in which inspection reports and other required information held was reviewed. Despite orders by an inspector being issued to the licensee on November 7, 2014, February 26, 2015, and August 6, 2015, these orders were not posted in the home. [s. 79. (3) (l)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations; and to ensure that required information for the long-term care home's procedure for initiating complaints to the licensee is posted; and to ensure that required information for notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained is posted; and to ensure that the required information, copies of the inspection reports from the past two years for the long-term care home is posted; and to ensure that the required information, orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years, is posted, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

On October 15, 2015, Inspector #577 observed S#100 independently prepare and administer insulin to resident #029, without a double-check from another staff member. Inspector asked S#100 about double-checking insulin and they reported that they do not perform double-checks with another staff member.

Inspector spoke with the DOC on October 15, 2015, who confirmed that it was not the home's policy to have staff double check their insulin. Inspector reviewed Janzen's policy, "Insulin Administration", p. 89, which indicated, 'calculate correct amount of insulin to administer, check insulin label with MAR again, have witness check dose'. Inspector reviewed policy with the DOC and they further reported that staff should have been following Janzen's medication policy, in regards to insulin administration. [s. 114. (3) (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 the written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, specifically in regards to the preparation of insulin, to be implemented voluntarily.

WN #14: 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 or a medication cart that was used exclusively for drugs and drug-related supplies and complies with manufacturer's instructions for the storage of the drugs.

On October 14, 2015, Inspector #577 examined the home's medication cart on one of the home units and found packages of hearing aid batteries in the medication drawers for residents #024, #025 and #004 and expired medication. Specifically, one roll of a pain reliever containing six tablets with expiration date of August 2015, for resident #028 who no longer resided in the home, one bottle of stool softener with expiration date of May 2015, and one inhaler with expiration date of August 2015, for resident #025.

Expired medications were confirmed with S#100. Staff S#101 confirmed that it is the responsibility of Janzen's pharmacy to be checking the medication carts for expired medication every three months.

On October 14, 2015, Inspector #577 spoke with the Director of Care(DOC) who confirmed that it is the responsibility of the Registered Practical Nurse's to be checking medication for expiry dates and there are monthly medication room audits completed by the RPN's.

On October 15, 2015, Inspector #577 reviewed Janzen's medication policy, "Destruction of Medications". On p. 53, the policy indicated that 'medications that are discontinued, expired, or remain after the resident leaves the facility, are destroyed and disposed of by the facility in accordance with applicable federal and provincial laws and regulations, medications awaiting destruction and disposal by the facility are documented on the record of drug destruction sheet and stored in a locked, secure area designated for that medication and medications should be destroyed before disposal to ensure that they cannot be used or consumed'. [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 or a medication cart that is used exclusively for drugs and drug-related supplies and complies with manufacturer's instructions for the storage of the drugs., to be implemented voluntarily.

WN #15: 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:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

On October 6, 2015, at 1000hr, Inspector #196 observed S#119 provide wound care treatment to resident #035 outside of the medication room on one of the home units. The provision of treatment, specifically the removal of a dressing, cleansing of the area and re-dressing the wound, was within view of other residents, staff and visitors. [s. 3. (1) 8.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, specifically for resident #012 and #015.

Inspector #196 observed resident #015 in bed on October 7 and 14, 2015, with bed rails raised.

An interview was conducted with the DOC on October 13, 2015, and they reported that residents are provided with a bed at the time of admission to the home and the bed systems had not been assessed specifically for them and the use of bed rails was based upon a resident's ability to self transfer and their past history of use. [s. 15. (1) (a)]

2. On October 7, 2015, Inspector #196 observed resident #012's bed with bed rails raised.

An interview was conducted with the DOC on October 13, 2015, and they reported that residents are provided with a bed at the time of admission to the home and the bed systems had not been assessed specifically for them and the use of bed rails was based upon a resident's ability to self transfer and their past history of use.

An interview was conducted with S#114 on October 15, 2015, and they reported that resident #012 required the use of bed rails. They also reported that when a resident was admitted to the home, four bed rails were raised at the time of admission and then it was

altered as needed, by resident or staff suggestion. [s. 15. (1) (a)]

3. The licensee has failed to ensure that where bed rails were used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #015 was observed lying in bed on October 14, 2015, with bed rails raised and told the inspector that they put a pillow between their arm and the bed rail as their arm gets caught.

The current care plan notes under focus problem of "falls/balance" included the intervention of bed rails up when in bed.

An interview was conducted with S#114 on October 15, 2015, and they reported that bed rails were used for resident #015. The DOC reported to Inspector #196 that the zones of entrapment had not been assessed on resident beds and according to S#120, they were not aware of potential zones of entrapment nor have they been checking for this. [s. 15. (1) (b)]

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On October 5, 2015, Inspector #577 observed resident #009 to have unclean ambulation equipment. Specifically, the cushion on their walker was soiled with food stains and food debris. On October 13 and 15, 2015, Inspector made similar observations of resident #009's walker cushion soiled with food stains and food debris.

On October 5, 2015, Inspector #196 observed resident #006 to have unclean ambulation equipment. Inspector observed their wheelchair frame and footrests to be unclean with food debris and dust. On October 13, 14, and 15, 2015, Inspector #577 made similar observations. Specifically, their walker cushion was soiled with food stains and food debris and their wheelchair cushion and wheelchair frame had food stains and food debris.

On October 13, 2015, Inspector #577 spoke with S#121 and S#122, who both reported that it was the responsibility of the night staff to clean walker's and wheelchair's according to a schedule. S#122 also reported that there was a wheelchair cleaner on the second floor and ambulation equipment can be cleaned as needed by all staff. Inspector reviewed the home's "Night routine for PSW's", which indicated that night staff were to wash wheelchairs and walkers during their shift, as per 'night book' and sign them off.

On October 14, 2015, Inspector #577 reviewed home's policy "Cleaning-Decontamination of equipment", #IC 2-40, dated September 2014. The policy indicated that nursing staff used a wheelchair washer on non-electrical wheelchairs and electrical wheelchairs were cleaned with a hospital disinfectant. Inspector spoke with the DOC who reported that night staff cleaned resident walkers and wheelchairs on a rotation basis and as needed, and staff also communicated to the night staff when equipment needs cleaning. [s. 15. (2) (a)]

WN #18: 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 failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission.

On October 5, 2015, at 0945hr, during the initial tour of the home, Inspector #196 observed a north side tub room. In the cupboard of the room was an unlabelled comb and hair brush, both were soiled with hair and debris and two unlabelled disposable razors that had been used and two sets of unlabelled nail clippers that were soiled. S#116 reported that they did not know who these items belonged to and would dispose of them. [s. 37. (1) (a)]

WN #19: 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 resident #004 was reassessed using an interdisciplinary approach, and that actions were taken and outcomes evaluated after a significant change in weight.

A review of resident #004's electronic health care record found a weight change of 5.06% over a one month period from May 2015, to June 2015. This weight change was flagged in the electronic system as significant. Upon further review, there was no assessment related to this significant weight change by the home's Registered Dietitian (RD) or any other member of the interdisciplinary team.

A review of resident #004's electronic health care record found that the resident was high nutritional risk due related to a medical condition. The resident was receiving nutrition interventions to assist with oral intake with an expected outcome to maintain weight over the next three months.

During an interview with Inspector #593, on October 13, 2015, the home's RD reported that the last assessment they completed for this resident was for a team meeting requested by the family. The RD had not yet reviewed the weights for this resident as they had been away, however the process was that with any weight change, the nursing staff send an e-mail referral to the RD who then follows up with the resident. The RD reported that they would consider 5% weight change significant and further reported that they did not receive a referral from nursing staff related to this weight change.

During an interview with Inspector #593 on October 16, 2015, the DOC reported that the home's policy was that any significant weight change that was flagged in the electronic system were to be referred to the RD for assessment and this was the responsibility of registered staff.

A review of the home's policy: #LTC 5-10 Unintentional Weight Loss or Gain dated January 2013, identified that a significant unintentional weight change was defined as unplanned weight loss or gain of more than 5% of previous weight in a period of one month. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that resident #005 was reassessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated after a significant change in weight.

A review of resident #005's electronic health care record found a weight change of 10.5% over a six month period from April 2015, to October 2015. Upon further review, there was no assessment related to this significant weight change by the home's Registered Dietitian (RD) or any other member of the interdisciplinary team.

A review of resident #009's electronic health care record found that the resident was high nutritional risk and was receiving nutrition interventions to assist with oral intake with an expected outcome to maintain weight within the next three months.

During an interview with Inspector #593, October 13, 2015, the homes RD reported that the last assessment they completed for this resident was September 2015. The RD had not yet reviewed the weights for this resident, however the process was that with any weight change, the nursing staff send an e-mail referral to the RD who then follows up with the resident. The RD reported that they would consider 5% or more weight change significant and further reported that they did not receive a referral from nursing staff related to this weight loss.

During an interview with Inspector #593 October 16, 2015, the DOC reported that the home's policy was that any significant weight change that was flagged in the electronic system were referred to the RD for assessment and this was the responsibility of registered staff.

A review of the home's policy: #LTC 5-10 Unintentional Weight Loss or Gain dated January 2013 identified that a significant unintentional weight change was defined as unplanned weight loss or gain of more than 10% of previous weight in a period of six months. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 20th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), GILLIAN CHAMBERLIN (593), JULIE KUORIKOSKI (621), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2015_333577_0016
Log No. / Registre no:	026480-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 27, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	BETHAMMI NURSING HOME 63 CARRIE STREET, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Meaghan Sharp

To ST. JOSEPH'S CARE GROUP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_333577_0004, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that resident #015 and all other residents are protected from abuse by anyone and shall ensure that all residents are not neglected by staff.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #015 was protected from abuse by anyone.

On October 7, 2015, resident #015 reported to Inspector #196 that a staff member had abused them but they could not recall their name or when it had occurred.

Inspector #196 conducted an interview with a family member of resident #015 and they reported that a series of emails outlining care concerns and alleged harm had been forwarded to the previous Clinical Manager in May 2015, regarding PSW #106. Specifically, in April 2015, resident #015 was crying and hurt while being transferred by the PSW. The family member indicated to the Inspector that they had asked the PSW to stop the transfer but they had continued. Another incident was witnessed by a different family member in May 2015, which resulted in a skin injury to resident #015 when the PSW provided care. The emails were reviewed by Inspector #196 and included expressed concern about resident #015's health, safety and risk for harm when the PSW was providing their care and not listening to the resident's requests or following their direction. The family member also reported that the resident was afraid of the PSW, and this staff member was no longer assigned to provide their care

and ignored the resident and themself when they were in the dining room.

An interview with the DOC and the Manager of Employee Relations revealed that the PSW has been employed by the licensee, working in the role of Personal Support Worker since June 2014, not currently enrolled in an educational program for registered practical nurses, does not have the title of Registered Practical Nurse (RPN) and does not have a certificate as a PSW. In addition, the DOC reported that the PSW did not have mandatory education on zero tolerance of abuse and neglect of residents.

On October 15, 2015, Inspector conducted a telephone interview with the previous Clinical Manager which revealed that they did not report or forward this complaint to the Director at the MOHLTC. They reported that they did not believe it was abuse towards resident #015. Furthermore, they stated that they felt it was a communication problem.

During an interview with the current DOC, on October 15, 2015, there were no other investigation notes regarding the family complaint about care except for hand writing on the printed copies of the emails.

An interview conducted with the current DOC and the Staffing Coordinator on October 14, 2015, determined that neither were made aware that the PSW was not to provide care to resident #015.

PSW #106 provided care to resident #015 that resulted in harm to the resident. The PSW did not have a PSW certificate, was not registered as a practical nurse and did not have training in the prevention of abuse and neglect of residents.

Non-compliance have been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 19.(1)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm and the compliance history which despite previous non-compliance (NC)issued including one compliance order, NC has continued with this area of the legislation. [s. 19. (1)]
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_333577_0004, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee shall ensure that every alleged, suspected or witnessed incident of abuse and neglect is immediately investigated.

Grounds / Motifs :

1. The licensee has failed to ensure that the alleged or suspected abuse of resident #015 was investigated.

On October 7, 2015, resident #015 reported to Inspector #196 that a staff member had abused them but they could not recall their name or when it had occurred.

An interview was conducted with a family member of resident #015 and they reported to the Inspector that a series of emails that expressed concern and alleged harm had been sent to the previous Clinical Manager in May 2015, regarding PSW #106. The emails expressed concern about resident #015's health, safety and risk for harm when the PSW was providing their care and not

listening to the resident's requests or following direction. The family member also reported that the resident was afraid of the PSW, and this staff member was no longer assigned to provide their care and ignored the resident and themself when they were in the dining room.

On October 15, 2015, Inspector spoke with the previous Clinical Manager regarding the email concerns that the home had received from resident #015's family member concerning the PSW. They reported that they did not report or forward this complaint to the Director at the MOHLTC, as they did not believe that it was abuse toward resident #015. Furthermore, they stated that they felt it was a communication problem and that staff were bullying the PSW. They also reported that the PSW was told they were no longer to provide care to resident #015, as per the family members request. The Clinical Manager indicated that their investigation of the concerns included a discussion with the PSW regarding improper transfer of resident #015, not following policy for transfers and discussion of potential harm to resident #015. Inspector spoke with the current DOC and it was identified that there were no records of an investigation other than a few hand written notes on copies of the emails from the family member of resident #015.

Inspector #196 reviewed the licensee policy #LTC 5-70 titled "Complaints Management Program" with approval date of March 2015. Under 'Responsibility of Manager' it read:
-Investigates all verbal and written complaints and provide a response to the complainant within the time frame described above. Records are maintained, utilizing the "Internal Complaint Documentation Form(s)" part 1 and 2.
-Reports to the Ministry of Health and Long-Term Care all written complaints received".

Non-compliance had been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O 2007, s. 23.(1)(a)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates minimal harm or potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC has continued with this area of the legislation. [s. 23. (1) (a)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_333577_0004, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is to immediately report the suspicion and the information upon which it is based to the Director.

Grounds / Motifs :

1. The licensee has failed to report alleged abuse of resident #015.

On May 3, 2015, a family member of resident #015 forwarded an email to the previous Clinical Manager, concerning alleged harm to resident #015 by PSW #106.

On October 15, 2015, Inspector spoke with the previous Clinical Manager, who reported that the email concerns forwarded from the family member of resident #015 were not reported to the Director at the MOHLTC, as they did not believe that it was abuse toward resident #015. Furthermore, they stated that they felt it was a communication problem.

Non-compliance had been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O 2007, s. 24.(1)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm/risk and the compliance history which despite previous non-compliance (NC) issued including a compliance order, NC has continued with this area of the legislation. [s. 24. (1)] (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 04, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 27th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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