Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public
Name of Director:	Stacey Colameco, Director (A)
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 **X** Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2018_703625_0001
Licensee:	St. Joseph's Care Group 35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7
LTC Home:	Bethammi Nursing Home 63 Carrie Street THUNDER BAY ON P7A 4J2
Name of Administrator:	Janine Black

Background:

The licensee of Bethammi Nursing Home ("the home") is currently in non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 ("Regulation"). The home is located in Thunder Bay and is licensed for 112 beds.

On March 26, 2018, as a part of a Resident Quality Inspection (#2018_703625_0001), a Director's Referral was made in accordance with s.152, paragraph 4 of the LTCHA.

Director's Referral #001 was issued for failure to comply with LTCHA, s. 8(1)(a) and 8(1)(b), Nursing and personal support services. Specifically, s. 8(1) requires that every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

(b) an organized program of personal support services for the home to meet the assessed needs of the residents.

The inspection revealed a pervasive scale of non-compliance within the home. Resident Quality Inspection #2018_703625_0001 dated March 26, 2018, resulted in 23 written notifications (WN), 10 voluntary plans of corrections (VPC), 8 compliance orders (CO) and one Director's Referral. The COs and Directors Referral issued under the *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 ("Regulation") were related to:

- LTCHA, 2007 S.O. 2007, s. 8 (1) (a), for failing to ensure that an organized program of nursing services for the home to meet the assessed needs of the residents, resulting in a Director's Referral.
- LTCHA, 2007 S.O. 2007, s. 8 (1) (b), for failing to ensure that an organized program of personal support services for the home to meet the assessed needs of the residents, resulting in a Director's Referral.
- LTCHA, 2007 S.O. 2007, s.6. (9), for failing to ensure that the provision of care set out in the plan of care was documented.
- LTCHA, 2007 S.O. 2007, c.8, s. 19(1) for failing to ensure that residents were protected from abuse by anyone and were not neglected by the licensee or staff.
- O. Reg. 79/10, s. 50 (2), for failing to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.
- O. Reg. 79/10, s. 129. (1), for failing to ensure that drugs were stored in an area or a medication cart that was secured and locked.
- O. Reg. 79/10, s. 54., for failing to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.
- O. Reg. 79/10, s. 71. (3), for failing to ensure that each resident was offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner, and a snack in the afternoon and evening.

In addition to the aforementioned compliance orders, the Inspectors issued VPCs for:

- LTCHA, 2007 S.O. 2007, s.6. (7), for failing to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
- LTCHA, 2007 S.O. 2007, s.6.(1), for failing to ensure that the written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.
- LTCHA, 2007 S.O. 2007, c.8, s. 3(1) for failing to ensure that the rights of residents were fully respected and promoted, including the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
- O. Reg. 79/10, s. 8. (1)(b), for failing to ensure that, where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan,

policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

- LTCHA, 2007 S.O. 2007, c.8, s. 20 (1), for failing to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.
- O. Reg. 79/10, s. 30. (2), for failing to ensure that, any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.
- O. Reg. 79/10, s. 33. (1), for failing to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
- O. Reg. 79/10, s. 51. (2)(c), for failing to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.
- O. Reg. 79/10, s. 110. (1)(2); s. 110. (7) 7., for failing to ensure that with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, staff applied the physical device in accordance with any manufacturer's instructions; failing to ensure that the physical device was well maintained; failing to ensure that every release of the device and all repositioning were documented.
- O. Reg. 79/10, s. 114. (2), for failing to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.
- O. Reg. 79/10, s. 229. (10) 1., for failing to ensure that that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and documented results of this screening were available to the licensee.

Written Notifications issued during the inspection issued included:

- LTCHA, 2007 S.O. 2007, c.8, s. 22 (1), for failing to ensure that, if a written complaint concerning the care of a resident or the operation of the long-term care home was received by the licensee, it was immediately forwarded to the Director.
- O. Reg. 79/10, s. 31. (2), for failing to ensure that there was a written staffing plan for the nursing and personal support services programs referred to Ontario Regulation 79/10, s. 31 (1) (a) and (b).
- O. Reg. 79/10, s. 34. (1)(b), for failing to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included physical assistance or cueing to help a resident who could not, for any reason, brush his or her own teeth.
- O. Reg. 79/10, s. 57. (2), for failing to ensure that if the Resident's Council had advised the licensee of concerns or recommendations, the licensee within ten days of receiving the advice, responded to Resident's Council in writing.

- O. Reg. 79/10, s. 122. (1)(a), for failing to ensure that no drug was acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug had been prescribed for a resident or obtained for the purpose of the emergency drug supply referred to in section 123.
- O. Reg. 79/10, s. 122. (1)(a), for failing to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Order:	

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to the following Legislative and Regulatory requirements:

1) *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.

2) *LTCHA*, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,

   a) An organized program of nursing services for the home to meet the assessed needs of the residents; and
   b) An organized program of personal support services for the home to meet the assessed needs of the residents.

3) O. Reg. 79/10, s. 50 (2) Every licensee of a long-term care home shall ensure that,

   a) a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff,
      i) Within 24 hours of the resident's admission
      ii) Upon any return of the resident from hospital, and
      iii) Upon any return of the resident from an absence greater than 24 hours;
   b) A resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
      i) Receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

- ii) Receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
- iii) Is assessed by a registered dietician who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
- iv) Is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

c) The equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

d) Any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.

4) O. Reg. 79/10, 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 the manufacturer's instructions for the storage of the drugs; and

b) Controlled substances are stored in separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

5) O. Reg. 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,

a) Identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and

b) Identifying and implementing interventions.

6) O. Reg. 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,

a) Three meals daily,

b) A between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and

c) A snack in the afternoon and evening.

Order: St Joseph's Care Group ("the licensee") is ordered:

1) To bring in a consultant from an external company with extensive experience in managing or operating long-term care homes to conduct a review and make recommendations for improvement regarding the following:

a) The nursing program within the home to ensure that it is organized to meet the assessed needs of the residents, including 24 hour nursing care;

b) The program of personal support services for the home to ensure that it is organized to meet the assessed needs of the residents;

c) The staffing plan within the home to ensure that it meets the assessed needs of residents and is evaluated and updated as necessary;

d) Provision of care set out in the plan of care, including outcomes and effectiveness of the plan of care;

e) The home's zero tolerance of abuse and neglect policies to ensure they are in compliance with the requirements under the LTCHA and Regulation;

f) The Skin and Wound Care program to ensure that it provides for routine skin care to prevent wounds, strategies to promote the prevention of infection, including monitoring of residents, and strategies to transfer and position residents;

g) The safe storage of medications;

h) The home's policies as they relate to the identification, management and documentation of responsive behaviours; and

i) The Nutrition and Hydration program.

2) Upon completion of the review, the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and the findings must be completed no later than June 15, 2018.

Within two weeks of receiving the report, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. That plan will be reviewed by the Director and may be changed based on the Director's review of the report and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the recommendations and any action(s) identified by the Director.

All of the plans are to be submitted to Stacey Colameco, Director (A) by fax to 416-327-7603 or courier to Ministry of Health and Long-Term Care, 11th Floor, 1075 Bay Street, Toronto, Ontario, M5S 2B1 by June 29, 2018.

Grounds:

This Order is necessary given the scope and severity of the non-compliance identified in inspection #2018_703625_0001, outlined below. This Order is being issued to ensure that the licensee addresses the serious and on-going non-compliance identified below by taking the actions identified by the Director in this Order, in addition to the actions identified by inspectors in the eight compliance orders (CO#001, #002, #003, #004, #005, #006, #007 and #008) issued following Inspection #2018_703625_0001, in order to achieve compliance.

As Director, I have relied on the evidence gathered in Inspection #2018_703625_0001. I have reviewed the inspection report, the Orders issued and the evidence collected by the inspector. I have also reviewed the inspectors' analysis of the scope, severity and the compliance history associated with the non-compliance identified.

Based on this, I have determined that this Director's Order is warranted given that non-compliance with *LTCHA*, s. 8. (1) (a)(b) was found, the inability of the licensee to achieve compliance, the staffing instability at the home and the additional non-compliance with the LTCHA identified as part of inspection #2018_703625_0001. These reasons, along with the significant number of findings of non-compliance, demonstrate that the licensee cannot identify corrective actions or develop a plan to address the non-compliance. Therefore, an external consultant is required to review and make recommendations so that that the licensee can adopt them to address the non-compliance through a plan.

Evidence demonstrating the recent staffing instability and its impact on resident care is provided in inspection report #2018_703625_0001 and includes the following:

- A weekly wound assessment had not been documented for three residents in excess of three months. Staff had cited staffing issues for the lack of documentation.
- Breaches of the resident's right to be afforded privacy in treatment and in caring for his or her personal needs were occurring during dining service. Workload was indicated as the reason for this.
- A review of staffing documents revealed that there were six night shifts where there was no RPN in the home and one night shift where there was no RN in the home.
- Residents were not receiving their scheduled baths; bathing flow sheet reports for January 2018 identified that no resident had all of their scheduled baths documented.
- Residents waited in excess of 19 to 75 minutes for their call bells to be responded to.
- Between-meal nourishment was not being provided. 48 out of 56 residents in a specific home area, had no documented nourishment provided in January.
- An incident of resident neglect was directly related to staffing deficiencies as acknowledged by the home's Administrator.

- A resident with responsive behaviours was ordered increased supervision. The supervision was not provided; as a result, six separate altercations occurred causing injury. In January 2018, the resident did not receive the increased supervision 98 per cent of the time.
- The home had no written Staffing Plan as required under O Reg. 79/10, s. 31(2).

The areas of non-compliance issued in inspection #2018_703625_0001 and that are relevant to this Order are detailed below. Direction is being provided in this Order to ensure that the licensee takes action, in addition to the actions ordered by the Inspectors, to address the following areas of non-compliance.

For non-compliance related to *LTCHA*, s. 8. (1)(a)(b)

The Director has ordered the licensee to obtain an external consultant to initiate a review of the nursing and personal support services programs in the home to ensure they are structured to meet the needs of the residents. In addition, the licensee is ordered to ensure the staffing plan is reviewed to ensure it meets the needs of residents and their assessed care needs. Upon review, the licensee will be required to act on any recommendations from that review.

Staffing shortages detailed in the inspection report impacted multiple areas of resident care, as noted above. They were not isolated to a specific resident care concern or a specific unit within the home. A review of the home's staffing complement identified that during the month of December 2017, there were ten day and six evening shifts where the home was short an RPN. This resulted in eight shifts where only 50 to 67 per cent of the scheduled RPNs, were in the home to care for 112 residents.

During one of the evening shifts where only two RPNs were in the home, there was also no RN in the home from 1500 hours to 1900 hrs. On the night shift of December 8, 2017 there was no RPN in the home. During the month of January 2018, there were: 19 day shifts where the home did not have the full RPN complement working, including 14 day shifts, where one or more RPN(s) were missing for the entire 0700 to 1500 hrs shift; and nine evening shifts where the home did not have the full RPN complement working, including eight evening shifts where one RPN was absent for the entire 1500 to 2300 hrs shift.

An analysis of the staffing complement determined that there were 17 day and evening shifts where two RPNs worked during the shift, including 15 shifts, where two RPNs out of three to four RPNs, or 50 to 67 per cent of the RPNs scheduled, worked for the entire shift. There were six night shifts where there was no RPN in the home and one night shift where there was no RN in the home.

Work load concerns related to staff working without a full complement of PSW staff were brought to the Director of Nursing and Personal Care. Despite the administration team's awareness of the staffing shortages occurring, the licensee did not put in place appropriate strategies or actions to address the staffing shortage, which negatively impacted resident care.

Multiple staff told the Inspector that they had worked short and that care was not delivered as per the resident's plan of care. They also stated that they were unable to answer call bells in a timely manner. They expressed concern for the residents' safety as residents had to wait for assistance for continence related transfers.

For non-compliance related to LTCHA, 2007 S.O. 2007, c.8, s. 19(1), and O. Reg. 79/10, s. 54

The Director has ordered the licensee to protect residents from abuse by anyone and ensure that residents are not neglected by the licensee or staff. In addition the Licensee is ordered to review and make recommendations to the home's zero tolerance of abuse and neglect policies to ensure they are in compliance with the requirements under the LTCHA and Regulation.

During the course of inspection the Inspectors identified resident neglect. A critical incident report submitted by the home to the Director identified that a resident was neglected on a day in January 2018. The report detailed that the resident had been sitting in a wheelchair seat that was soaked and dripping with bodily fluid, and that the resident's continence had not been attended to. In an interview the home's Administrator acknowledged that a resident's continence care needs were not met due to staffing issues.

A complaint was received by the Director concerning a resident with responsive behaviours in the home that was required to have increased monitoring and was not. The complainant indicated that the resident was a risk to other residents. The inspection report describes that the licensee failed to provide supervision; as a result, six separate altercations occurred causing injury. In interviews the DOC and Administrator acknowledged that the resident's triggers, behaviours and strategies documented by Behavioural Support Ontario and the nursing intervention of increased monitoring were not incorporated into resident's care plan.

The Inspector also reviewed two critical incident reports submitted by the home to the Director regarding incidents of alleged neglect of residents, by staff. Despite staff having witnessed the alleged neglect, staff failed to appropriately adhere to the homes Zero Tolerance of Abuse and Neglect Policy, when they failed to immediately report the incidents.

For non-compliance related to O. Reg. 79/10, s. 50 (2)

The Director has ordered the licensee to obtain an external consultant to conduct a review and make recommendations to the home's Skin and Wound Care program to ensure that it provides for routine skin care to prevent wounds, strategies to promote the prevention of infection, including monitoring of residents, and strategies to transfer and position residents.

The Resident Quality Inspection revealed three resident having or being at high risk for pressure ulcers. All three residents were identified to be lacking weekly wound assessments. During an interview with the Inspector, a registered staff member stated that staff were supposed to

complete wound assessments in the "Wound Tracker" but had not been doing so, and had not been completing electronic progress notes for wound assessments, as they did not have enough time in the shift to do so. The registered staff member stated that staff generally did not have time to complete wound assessments, chart them, or adhere to a daily schedule for wound assessment charting.

For non-compliance related to O. Reg. 79/10, s. 129. (1)

The Director has ordered the licensee to obtain an external consultant to conduct a review and make recommendations ensuring the safe storage of medications.

During the Resident Quality Inspection compliance order #001 was issued from inspection #2017_463616_0007 pursuant to r. 129 (1) (a) (ii). The licensee was ordered to ensure that drugs were stored in an area or a medication cart that was secure and locked. The compliance due date was August 16, 2017.

Despite the issuance of the compliance order, the inspectors observed 31 topical medications unsecured in various areas throughout the home. As well, the inspector observed an injectable controlled substances stored in the second and third floor medication rooms without any lock in place except for the lock on the medication rooms' doors.

For non-compliance related to O. Reg. 79/10, s. 71. (3)

The Director has ordered the licensee to obtain an external consultant to conduct a review and make recommendations ensuring the efficacy of the home's Nutrition and Hydration program.

Complaints were received by the Director related to the impact that staffing shortages had on the provision of nursing and personal care services to residents. During interviews with the Inspector eight PSW staff stated that beverages and snacks were not given out to residents when the staff were working short.

During interviews with the Inspector a resident stated that, generally, beverages and snacks were not offered to them in the afternoons and evenings. In another resident interview, the resident stated that staff did not offer beverages to residents in between meals, and they hadn't been offered a snack in the afternoon or evening for the last seven days.

The Inspector reviewed a Dietary Report for January 2018, for a specific floor. With respect to the "PM snack" which included afternoon beverages and snacks for 56 residents, and identified that 100 per cent of residents in the specific home area had ten or less documented entries out of the 31 days in January, or less than 35 per cent of their afternoon beverage or snack entries documented.

Given the issues above and outlined in more detail in the inspection report, the licensee has not put in place strategies to effectively address the requirements of the LTCHA to ensure that there is a staffing mix that is consistent with the residents' assessed care and safety needs. It is also for these reasons that I am ordering the licensee to bring in an external consultant with expertise in long-term care to analyse the current staffing plan and prepare recommendations, as the licensee has not been able to put in place strategies to effectively address the issues themselves and achieve compliance.

In all aspects of the decision to issue this Director's Order, O. Reg. 79/10, s. 299(1) was in consideration. According to O. Reg. 79/10, s. 299(1), "For the purposes of sections 152 to 156 of the Act, in determining what actions to take or orders to make where there has been a finding of non-compliance with a requirement under the Act, an inspector or Director shall take all of the following factors into account, and shall take only those factors into account:

1. The severity of the non-compliance and, in cases where there has been harm or the risk of harm to one or more residents arising from the non-compliance, the severity of the harm or risk of harm.

2. The scope of the non-compliance and, in cases where there has been harm or risk of harm arising from the non-compliance, the scope of the harm or risk of harm.

3. The licensee's history of compliance, in any home, with requirements under the Act and with requirements under the Nursing Homes Act, the Charitable Institutions Act or the Homes for the Aged and Rest Homes Act, the regulations under those Acts and any service agreement required by any of those Acts. O. Reg. 79/10, s. 299 (1)."

The decision to issue this Director's Order was based on the scope and severity of non-compliance, and the compliance history. The scope is identified to be pervasive in the home and represents systemic failure that affects or has the potential to affect a large number of the homes' residents. The severity is determined to be actual harm or risk of actual harm. The Licensee's history of non-compliance is extensive; despite numerous Written Notifications, Voluntary Plans of Correction, and Compliance Orders, repeated and ongoing non-compliance with requirements under the LTCHA continue to occur at Bethammi Nursing Home.

This order must be complied with by:	June 29, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West

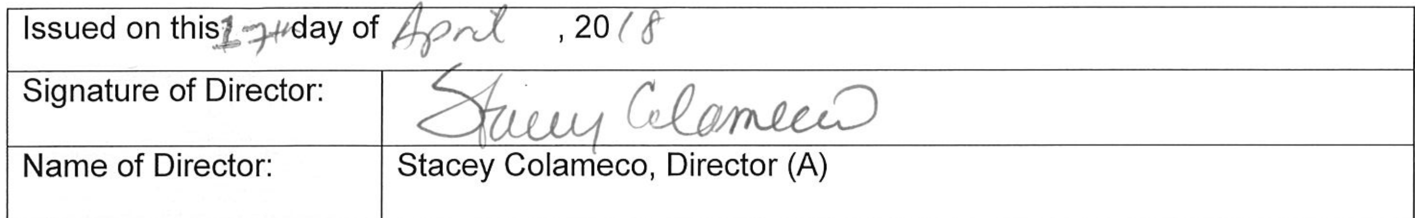
and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch

9th Floor
Toronto, ON
M5S 2T5

1075 Bay St., 11th Floor, Suite 1100
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.



Issued on this 17th day of April , 2018	
Signature of Director:	[signature]
Name of Director:	Stacey Colameco, Director (A)