Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection/ Genre d'inspection
Nov 12, 2014;	2014_182128_0011 (A1)	L-000676-14	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street, P.O. Box 1600, WALKERTON, ON, N0G-2V0

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

BRUCELEA HAVEN LONG TERM CARE HOME - CORPORATION OF THE COUNTY OF BRUCE
41 McGIVERN STREET WEST, P.O. BOX 1600, WALKERTON, ON, N0G-2V0

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

Ontario

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

RUTH HILDEBRAND (128) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Approval was given October 27, 2014 to extend the compliance date for Order #001 until January 15, 2015.

Issued on this 12 day of November 2014 (A1)

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

Ontario

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

RUTH HILDEBRAND (128) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 9 -11, 14-15, and 17-18, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Resident Care Coordinator, Volunteer Planner, Recreation and Leisure Manager, Food Service Supervisor, Environmental Service Supervisor, 2 Administration Assistants, Receptionist, Ward Clerk, 5 Registered Nurses, 10 Registered Practical Nurses, 17 Personal Support Workers, 1 Summer Student, 4 Dietary Aides, 2 Housekeeping Aides, 2 Recreation and Leisure Aides, 3 Family Members and 40+ Residents.

During the course of the inspection, the inspector(s) conducted a tour of all resident home, dining and common areas, and medication storage areas. The Inspectors observed resident

care, resident-staff interactions, dining service, medication passes and recreational activities. Relevant clinical records, home policies, procedures and meeting minutes were reviewed. Posting of required information was confirmed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Family Council

Food Quality

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

Quality Improvement

Reporting and Complaints

Residents' Council

Safe and Secure Home

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an organized program has been developed for each of the interdisciplinary programs required under section 48 of the Regulation, as evidenced by:

There was no documented evidence to demonstrate that the home had a written description of the four required programs including falls prevention and management, skin and wound care, continence and care bowel management, and pain management. There was no evidence to support that the home had developed goals and objectives, as well as relevant policies and procedures for each program.

A clinical record review on July 15, 2014 revealed that a continence assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not completed for Resident #026.

The Resident Care Coordinator and the Director of Care confirmed that the home does not have a clinically appropriate assessment instrument to assess continence and that they are in the initial stages of developing the continence program.

The Director of Care confirmed that the home's policies and procedures were outdated from 2003 and although components of the required programs are in place, the programs are not fully developed. [s. 30. (1) 1.]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, as evidenced by:

During Resident observations (July 9 to July 11, 2014), the following beds were noted to have bed rails which posed entrapment concerns:
Eight rooms had mattresses that did not fit the bed &/or no corner guards to hold the mattress in place and one room had a therapeutic surface on top of another mattress that was not affixed.

The Administrator verified that these beds had entrapment concerns, on July 11, 2014, after observing the identified beds.

After the risk was identified, the home completed another bed safety audit, on July 15, 2014, in which they identified 81/141 (57%) beds had failed the audit.

The DOC verified the number of beds identified in the audit was correct and stated the expectation of the home is to ensure Resident safety by ensuring there are no entrapment zones. [s. 15. (1) (b)]

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 O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, a care conference of the interdisciplinary team providing care was held at least annually to discuss the plan of care and other matters of importance to resident #002, and his or her substitute decision maker, as evidenced by:

A documented family care conference revealed it was only attended by nursing with written input from physiotherapy.

The Resident Care Coordinator confirmed that the family care conference did not include attendance nor input from dietary, activation, or restorative care.

The Director of Care shared that not all departments attend or provide input into the family care conferences on a regular basis throughout the home. [s. 27. (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 a care conference be held, within six weeks following the resident's admission and at least annually, including members of the interdisciplinary team to discuss the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 109. Policy to minimize restraining of residents, etc.
Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,
(a) use of physical devices; O. Reg. 79/10, s. 109.
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; O. Reg. 79/10, s. 109.
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; O. Reg. 79/10, s. 109.
(d) types of physical devices permitted to be used; O. Reg. 79/10, s. 109.
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; O. Reg. 79/10, s. 109.
(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and O. Reg. 79/10, s. 109.
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy under section 29 of the Act deals with
(a) use of physical devices;
(b) duties and responsibilities of staff, including,
(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,
(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;
(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when
immediate action is necessary to prevent serious bodily harm to the person or others;
(d) types of physical devices permitted to be used;
(e) how consent to the use of physical devices as set out in section 31 of the Act and the use
of PASDs as set out in section 33 of the Act is to be obtained and documented;
(f) alternatives to the use of physical devices, including how these alternatives are planned,
developed and implemented, using an interdisciplinary approach; and
(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with
the Act and this Regulation, as evidenced by:

A review of the home's written Restraint Policy, dated April 13, 2005, revealed that the policy was not in compliance with the LTCHA and regulations as it did not include all the requirements in section 109 of the regulation.

The Administrator, verified by telephone, on July 22, 2014, that the restraint policy was not in compliance with the LTCHA and Regulations and needs to be updated. [s. 109.]

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's restraint policy deals with, (a) use of physical devices; (b)duties and responsibilities of staff, including, (i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device, (ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device; (c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others; (d) types of physical devices permitted to be used; (e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented; (f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and (g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation, to be implemented voluntarily.

WN #5: 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 failed to ensure that drugs were stored in an area or medication cart that was secure and locked, as evidenced by:

An unlocked and unattended medication cart was observed during the inspection.

A Registered Nurse acknowledged that the medication cart was unlocked, unattended and should have been locked.

The Administrator, who was on tour with Inspector #128 and # 520, confirmed that the expectation was that if the medication cart was out of sight then it was to be locked. [s. 129. (1) (a) (ii)]

2. The licensee failed to ensure that controlled substances are stored in a separate, double-locked area within the locked medication cart, as evidenced by:

During medication observation it was noted that the narcotics bin was unlocked within the medication cart.

The Registered Practical Nurse verified that the narcotics bin was unlocked and stated the expectation of the home was to have a locked narcotics bin within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or medication cart that is secure and locked and that controlled substances are stored in a separate, locked area within the locked medication cart, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee failed to ensure that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, as evidenced by:

Observations of medication storage rooms revealed the practice by Registered Staff was to discard medications that were being destroyed into a bin without first denaturing the medication. Whole strip packages were discarded into the bin without removal of PHI or denaturing of the drug.

This was verified by the Resident Care Coordinator on July 17, 2014.

The Administrator acknowledged by telephone, July 22, 2014, that as part of the drug destruction and disposal system, drugs were not being denatured. [s. 136. (6)]

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 when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's quality improvement and utilization review system provided a written description of its policies, procedures and protocols, as evidenced by:

The home has components of a quality improvement program in place. However, the policies in place are dated July 2004, February - July 2006, November 2008 and January 2009 which make reference to the Long-Term Care Facilities Program Manual and do not reflect the Long Term Care Homes Act and Regulations.

The Director of Care acknowledged the Quality Improvement policy and procedure manual is outdated and does not provide direction.

The Administrator stated on the RQI LTCH Licensee Confirmation Checklist, for Quality Improvement, that the Quality Improvement system is not ongoing, interdisciplinary and does not provide a written description of its goals, objectives, policies, procedures, and protocols and does not have a process in place to identify initiatives for review. [s. 228. 1.]

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's quality improvement and utilization review system provides a written description of its policies, procedures and protocols, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program as related to hand hygiene, as evidenced by:

During a lunch meal, a Personal Support Worker was observed assisting three Residents with eating, by picking up half sandwiches from the Residents' plates and handing them to the Residents, without evidence of hand hygiene after clearing dirty dishes from tables.

The Personal Support Worker acknowledged that “he/she should have washed his/her hands” between handling dirty dishes and touching residents’ food.

The Director of Care confirmed that staff were expected to use hand hygiene between touching dirty and clean items.

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program as related to storage of personal care equipment, as evidenced by:

An unlabelled bed pan was observed sitting on the floor of a shared washroom.

A Personal Support Worker confirmed the observation and indicated that bed pans were not to be left on the floor.

The Director of Care acknowledged the expectation was that bed pans should not be left on the floor and indicated they were to be disinfected after each use and hung on the hooks in the washrooms. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program as related to hand hygiene and storage of personal care equipment, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, 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 are maintained in a safe condition and in a good state of repair, as evidenced by:

Inspector # 128 noted, on July 10, 2014, in the 2 South Spa Room, that there were walls and door frames with chipped paint, plus a small amount of wall damage near the door to the tub room. There was also rust on the transfer pole.
Inspector # 128 noted, on July 10, 2014, in the 2 West Spa Room, that the door had paint chipped from it, the base board next to the door was damaged, the transfer pole was rusted with chipped paint, and the shower contained a lime build up on the walls and floor.
In addition it was noted the carpets were stained and worn throughout the hallways and lounges.

Inspector # 588 noted on July 9, 2014 that the wall under the light switch to the washroom of Resident #002's room had damage through the drywall into the plaster.

In Spa Room # 472, the shower area revealed a heavy lime build up about 12x24 inches from below the tap to the drain. The tub had a blue rubber strip that was coming off the tub and was hanging down about 5 inches.

These issues were confirmed by the Environmental Services Manager through observation. [s. 15. (2) (c)]

2. It was noted that the areas requiring attention by maintenance were repaired during the inspection, except for the transfer poles in spas on 2 west and 2 south and the damaged wall in the spa on 2 west. Maintenance personnel shared that the transfer poles were expected to be repaired before inspectors left the building. [s. 15. (2) (c)]

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that on an ongoing basis residents' families and persons of importance to residents were advised of the right to establish a Family Council; and convene semi-annual meetings to ensure such persons were advised of the right to establish a Family Council, as evidenced by:

a. The home does not have a Family Council.

There is no documented evidence to support that the home advises families on an ongoing basis that they have the right to establish a Family Council.

The Director of Care and Volunteer Planner both confirmed that families are not advised on an going basis.

b. One family meeting was held in 2013. A review of the minutes from the Family Information Night, held April 25, 2013, revealed that families and persons of importance to residents were not advised of their right to establish a Family Council.

Two Administration Assistants confirmed that there were no minutes to support that semi-annual meeting were held in 2013.

One meeting was held February 22, 2014 where families were advised of their right to establish a Family Council.

The Director of Care confirmed that there is no documented evidence to support that the licensee convened semi-annual meetings to advise residents' families and person of importance to residents of their right to establish a Family Council. [s. 59. (7) (a)]

Issued on this 12 day of November 2014 (A1)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : RUTH HILDEBRAND (128) - (A1)

Inspection No. / No de l'inspection : 2014_182128_0011 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : L-000676-14 (A1)

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

Report Date(s) / Date(s) du Rapport : Nov 12, 2014;(A1)

Licensee / Titulaire de permis : CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street, P.O. Box 1600, WALKERTON, ON, N0G-2V0

LTC Home / Foyer de SLD : BRUCELEA HAVEN LONG TERM CARE HOME - CORPORATION OF THE COUNTY OF BRUCE
41 McGIVERN STREET WEST, P.O. BOX 1600, WALKERTON, ON, N0G-2V0

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Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : ELEANOR MACEWEN

To CORPORATION OF THE COUNTY OF BRUCE, 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)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 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. 30 (1).

Order / Ordre :

The licensee must ensure that the four Required Programs, in section 48 of the Regulation, including falls prevention and management, skin and wound care, continence care and bowel management and pain management are fully developed and including:

A written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

Grounds / Motifs :

1. The licensee failed to ensure that an organized program has been developed for each of the interdisciplinary programs required under section 48 of the Regulation, as evidenced by:

There was no documented evidence to demonstrate that the home had a written description of the four required programs including falls prevention and management, skin and wound care, continence care and bowel management, and pain management. There was no evidence to support that the home had developed goals and objectives, as well as relevant policies and procedures for each program.

A clinical record review on July 15, 2014 revealed that a continence assessment using a clinically appropriate instrument that was specifically designed for assessment of incontinence was not completed for Resident #026.

The Resident Care Coordinator and the Director of Care confirmed that the home does not have a clinically appropriate assessment instrument to assess continence and that they are in the initial stages of developing the continence program.

The Director of Care confirmed that the home's policies and procedures were outdated from 2003 and although components of the required programs are in place, the programs are not fully developed. (128)

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

Jan 15, 2015(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(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).

Order / Ordre :

The licensee must ensure that where bed rails are used that each resident is assessed and his or her bed system is evaluated and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, as evidenced by:

During Resident observations (July 9 to July 11, 2014), the following beds were noted to have bed rails which posed entrapment concerns:
Eight rooms had mattresses that did not fit the bed &/or no corner guards to hold the mattress in place and one room had a therapeutic surface on top of another mattress that was not affixed.

The Administrator verified that these beds had entrapment concerns, on July 11, 2014, after observing the identified beds.

After the risk was identified, the home completed another bed safety audit, on July 15, 2014, in which they identified 81/141 (57%) beds had failed the audit.

The DOC verified the number of beds identified in the audit was correct and stated the expectation of the home is to ensure Resident safety by ensuring there are no entrapment zones. (520)

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

Oct 31, 2014

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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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
Toronto ON M5S 2B1
Télécopieur : 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 12 day of November 2014 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUTH HILDEBRAND - (A1)

Service Area Office /
Bureau régional de services : London