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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Sep 21, 2016	2016_339617_0023	011643-16	Resident Quality Inspection

Licensee/Titulaire de permis

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

SHEILA CLARK (617), JULIE KUORIKOSKI (621)

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): June 13, 14, 15, 16, 17, 20, 21, 22, 23, 24, 2016

Throughout the inspection, the inspectors directly observed the delivery of care and services to residents in all home areas, directly observed medication passes, directly observed various meal services, reviewed resident health care records, reviewed staffing patterns and reviewed various home policies and procedures.

In addition to this inspection the following Intakes were completed relating to:
-follow up to Compliance Orders #001, #002, #003, & #005, previously issued to the home regarding the prevention of resident abuse, Intake #005924-16,
-follow up to Compliance Orders #004 & #006, previously issued to the home regarding training in the prevention of resident abuse, Intake #005921-16,
-a complaint regarding resident care and services, Intake #003531-16, and
-two critical incidents reported to the Director, Intakes #023077-15 (Resident to Resident Abuse) & #010734-16 (Resident burn).

During the course of the inspection, the inspector(s) spoke with the inspector(s) spoke with the Chief Executive Officer (CEO), the Chief Nursing Officer (CNO), Nurse Manager, Registered Staff (RNs and RPNs), Resident Assessment Instrument Minimal Data Set (RAI MDS) Lead, Support Services Manager, Personal Support Workers (PSWs), Kitchen Staff, Maintenance Staff, House Keeping Staff, Recreation Staff, Anishawbe Resource Worker, Staff Educator, Physiotherapy Staff, Social Worker, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
9 WN(s)
4 VPC(s)
2 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
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2015_433625_0007	617
O.Reg 79/10 s. 221. (2)	CO #006	2015_433625_0007	617
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #003	2015_433625_0007	617
O.Reg 79/10 s. 96.	CO #005	2015_433625_0007	617

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend

WN – Written Notification
VPC – Voluntary Plan of Correction
DR – Director Referral
CO – Compliance Order
WAO – Work and Activity Order

Legendé

WN – Avis écrit
VPC – Plan de redressement volontaire
DR – Aiguillage au directeur
CO – Ordre de conformité
WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).

Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

The licensee failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff by not complying with previously issued compliance order (CO) #001.

Previous Inspection #2015_433625_0007 issued the home CO #001 pursuant to LTCHA, S. O. 2007, s 19 (1), on February 19, 2016. The home was to be compliant by April 15, 2016, regarding the following orders from the Inspector:

a) Review and revise all policies related to resident abuse and neglect to ensure that they are in compliance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

b) Train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

c) Develop and implement a system to monitor compliance with the home's abuse and neglect policies.

d) Develop and implement a system to ensure that staff are familiar with the current care plans for each patient and resident they provide care to including, but not limited to, interventions to address harmful or potentially harmful interactions.

e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse.

f) Immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

g) Notify the resident's Substitute Decision Maker (SDM) immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and notify the SDM within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

In relation to item "b" under compliance order #001, Inspector #617 found that staff working on, or having responsibility for, the long-term care unit were not trained on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10, at the time of the inspection.

In June, 2016, Inspector #617 interviewed the following staff members who reported that they had not been trained in the revised abuse and neglect policies related to abuse prevention, recognition, response and reporting requirements: HSK #118, HSK #119, Kitchen Staff #120, and Anishnawbe Resource Worker #121.

During interviews with Nurse Manager #103, the Chief Nursing Officer, and the Staff Educator, it was confirmed to the Inspector that not all staff have been trained in the revised non-abuse policies. It was explained that the home had planned the training in four phases. The first phase was completed where all direct care staff including the PSWs and the RPNs were trained. Phase two, three and four had not yet been scheduled which involved the support staff in housekeeping, dietary, maintenance, the Anishnawbe Resource Worker, Recreation Aides, RNs, and Volunteers.
[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. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

The licensee has failed to ensure that the persons who had received training under subsection (2) received retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations by not complying with a previously issued compliance order (CO) #004.

Previous Inspection #2015_433625_0007 issued the home CO #004 pursuant to LTCHA, S. O. 2007, s 76 (4), on February 19, 2016. The home was to be compliant by April 15, 2016, regarding the following orders from the Inspector:

a) Provide training to all staff in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

b) Provide training to all staff prior to performing their responsibilities, annually and at any other time determined necessary by the licensee in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

c) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of the content.

d) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and post-training staff evaluations.

In relation to item "a" under CO #004, Inspector #617 found that training was not provided to all staff in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

In June, 2016, Inspector #617 interviewed the following staff members who reported that they had not been trained in the areas of the Residents' Bill of Rights, the home's revised policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26: HSK #118, HSK #119, Kitchen Staff #120, and Anishnawbe Resource Worker #121.

During interviews with Nurse Manager #103, the Chief Nursing Officer, and the Staff Educator, it was confirmed to the Inspector that not all staff had been trained in the in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections. The Staff Educator explained that the home had planned the training in four phases. The first phase was completed where all direct care staff including the PSWs and RPNs were trained. Phase two, three and four had not yet been scheduled which involved staff in housekeeping, dietary, maintenance, the Anishnawbe Resource Worker, Recreation Aides, RNs, and Volunteers.
[s. 76. (4)]

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. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plans of care for residents #003 and

#001 set out clear directions to staff and others who provide direct care to the residents.

Inspector #621 reviewed the diet orders from resident #003’s chart dated from August, 2015, and the most current written plan of care dated May, 2016, which both identified that the resident was to receive a nutritional intervention at specific times. However, a review of resident #003’s Medication Administration Record (MAR) last dated May, 2016, did not identify an order for the nutritional intervention.

RPN #100 reviewed the MAR, most recent Care Plan and the diet orders on the chart and identified to the Inspector that this resident was to receive the nutritional intervention at specific times, that the order had been made by the physician in August, 2015, and that there had been no subsequent order to discontinue it.

A review of the most recent progress notes, nutrition assessment and care plan updates from the Registered Dietitian from February, 2016, reported that the resident was to continue with the nutritional intervention at specific times to support nutrition and hydration needs.

Nurse Manager #103 reviewed the orders for this resident and reported that the nutrition intervention was ordered and there was no record of discontinuation. They indicated that the order for the nutrition intervention should have been on the MAR as prescribed and confirmed that the written plan of care did not set out clear directions for the nutrition intervention as prescribed and should have.
[s. 6. (1) (c)]

2. Inspector #621 observed specific bed rails in the up position on resident #001’s bed.

During an interview with resident #001, they confirmed to Inspector #621 that they used bed rails for repositioning while in bed and that this met their needs.

Nurse Manager #103 with Inspector #621 observed the resident's bed system and identified that this resident had specific bed rails up. The Nurse Manager #103 further reported that all the bed systems in the home were designed for use of either quarter or three-quarter bed rails.

Nurse Manager #103 reported that it is their expectation that any information on use of bed rails was to be documented and updated by the RPN on the hard copy of the most recent care plan and that this information would then be entered into the electronic care

plan quarterly by the RAI Lead.

The Inspector reviewed resident #001’s care plan and found:
a) ADL Functional/Rehabilitation, it identified that staff ensure that specific bed rails were up on the bed as ordered for safety;
b) Falls/Balance section, it identified that this resident required a different bed rail up on bed to promote bed mobility; and
c) Safety Devices section, it identified in two separate entries that again different bed rails were to be up and were used.

Nurse Manager #103 reported that the information identified in the care plan did not provide clear direction related to the use of bed rails. [s. 6. (1) (c)]

3. A complaint was submitted to the Director regarding concerns of resident #001's care provision. The complainant reported that resident #001 had been getting up every morning at a certain time and now this is not happening anymore because there is not enough staff available to provide assistance.

Over four days in June, 2016, in early morning, Inspector #617 observed resident #001 in the hallway. Resident #001 had finished breakfast and was on their way back to their room.

A review of resident #001's Resident Assessment Instrument Minimal Data Set, revised in June, 2016, indicated their cognitive status and level of staff supervision, their required level of transfer assistance from staff, and identified their mode of mobility.

A review of resident #001's care plan located at the nursing station, instructed the PSWs to assist the resident up in the morning at two different times.

In June, 2016, the Inspector interviewed PSW #109 who reported that resident #001 was assisted out of bed between a specific hour daily by two staff and use of an assistive device. PSW #109 further explained that night staff would not be able to assist resident #001 to get out of bed before a certain time because there were only two staff on the unit at that time.

PSW #109 reviewed resident #001's care plan located at the nursing station and confirmed to the Inspector that the care plan instructed staff to get the resident out of bed at two different times. PSW #109 confirmed that resident #001's plan of care did not give

clear direction on when to get the resident up in the morning. [s. 6. (1) (c)]

4. On seven days, Inspector #617 observed a wandering deterrent at resident #001's room.

Inspector #617 interviewed resident #001 who reported to the Inspector that the wandering deterrent was intended to deter residents from wandering into their room. The Inspector interviewed RPN #100 who reported that the home tried to use a different deterrent but it had affected the resident's ability to enter their room.

Inspector #617 reviewed resident #001's care plan and was not able to identify interventions for the use of the wandering deterrent.

The Inspector interviewed PSW #109 who reviewed resident #001's care plan and confirmed to the Inspector that the use of the wandering deterrent was not identified in the plan and did not give directions for its use. [s. 6. (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 the written plans of care for the following residents sets out clear directions to staff and others who provide direct care to the resident for:
-resident #003's nutritional intervention
-resident #001's use of a safety device, level of staff assistance required with an activity of daily living, and use of a behavior deterrent, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Long Term Care Homes Act or Regulation 79/10 required the licensee of the long term care home to have, institute or otherwise put in place a policy, the licensee did not ensure that the policy was complied with.

Inspector #621 reviewed a Critical Incident (CI) report submitted to the Director in August, 2015, which alleged physical abuse involving resident #008 hitting resident #004 and causing injury.

An addendum to the CI dated December, 2015, identified that resident #004's Substitute Decision Maker (SDM) made a complaint regarding the incident, and that the CEO met with the SDM and addressed the SDM's concerns immediately. On review of the CI forwarded to the Director, Inspector #621 found no written record of the SDM's complaint or the home's response.

During an interview in June, 2016, Nurse Manager #103 reported to Inspector #621 that the previous CEO #122 confirmed that resident #004's SDM made a verbal complaint concerning the incident where resident #008 hit resident #004 and caused injury in August, 2015. Nurse Manager #103 reported that CEO#122 met with the SDM that same day and was able to resolve the issues identified by the SDM at that time.

A review of the home's policy titled "Complaint Process - LTC Policy N-C31", last revised March 2016, identified that all verbal complaints must be documented in writing on the complaint form, and that if the complaint was given verbally, the manager or staff completing the complaint form must record the statement of complaint and have the complainant sign the form confirming the content. It also identified that the LTC Nurse

Manager was responsible for the investigation, resolution and response of the complaint, and the Administrative Services Assistant was to maintain all documentation related to the complaint in a confidential file.

During an interview with Nurse Manager #103, they reported to the Inspector that there was no record of the SDM’s complaint being documented on the complaint form as per the home’s policy, and there was no documentation on file to outline the home’s response to the SDM’s concerns, and there should have been. [s. 8. (1) (b)]

2. A complaint was submitted to the Director from resident #001's Substitute Decision Maker (SDM) regarding a concern for the resident's provision of care by a member of the registered staff. During an interview with resident #001's SDM, it was reported to Inspector #617 that RPN #111 told resident #001 that it was okay for the resident to hit anyone who entered their room. The SDM felt this was unprofessional and reported the concern to the previous Nurse Manager #106 who did not seem concerned and did not follow up with the SDM.

The Inspector interviewed the Chief Nursing Officer (CNO) who confirmed that they were aware resident #001's SDM did verbally complain about the unprofessional behaviour of RPN #111 to the previous Nurse Manager #106 some time last year.

The Inspector reviewed RPN #111's personnel file and found that documentation regarding the complaint of unprofessional behaviour from resident #001's SDM was missing.

During an interview with the CNO, it was confirmed to the Inspector that they reviewed the previous Nurse Manager #106's historical notes and complaint forms. The CNO confirmed to the Inspector that they were not able to find documentation that resident #001's SDM verbal complaint was investigated or that resident #001's SDM was notified of the results. The CNO further explained that they expected that the previous Nurse Manager #106 did not follow the home's policy titled "Complaint Process - LTC Policy N-C31" which stated that the verbal complaints were to be investigated and its conclusion followed up with the complainant. [s. 8. (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 the home's policy regarding complaint management is complied with, to be implemented voluntarily.

WN #5: 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, residents #004 and #003 were assessed and their bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

Inspector #621 observed bed rails in the up position on resident #004's bed while they were sleeping.

A review of this resident's most current plan of care identified that staff were to ensure that specific bed rails were up when in bed to promote bed mobility.

During an interview with the RAI Lead, they reported to Inspector #621 that they completed bed rail risk assessments on admission, quarterly, and whenever there was a change in resident condition. They reported that this assessment was kept in hard copy on file with the resident's care plan on the unit.

On review of the resident chart and care plan binder with RPN #111, a completed bed rail risk assessment for resident #004 could not be found. [s. 15. (1) (a)]

2. Inspector #621 observed specific bed rails in the up position on resident #003's bed while they were sleeping.

A review of resident #003's most current plan of care identified under the Safety Devices section that staff were to ensure that these bed rails were up when in bed.

On review of the resident chart and care plan binder with RPN #111, a completed bed rail risk assessment for resident #003 could not be found.

During an interview with Nurse Manager #103 on June 20, 2016, they reported to Inspector #621 that the home had just started the process of completing bed rail risk assessments in the past six weeks and confirmed that the assessments for residents #003 and #004 had not been completed. [s. 15. (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 where bed rails used for residents #004 and #003 are assessed and their bed system evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that for resident #008 who was demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

During a review of resident #008's progress notes for a six month period in 2015, Inspector #621 identified 28 incidents of responsive behaviours.

Inspector #621 reviewed resident #008's chart and identified that during this six month period, responsive behaviours were documented using the Dementia Observation System (DOS) for three consecutive days in 2015, followed by another 17 days. For 27

out of 28 incidents of responsive behaviours documented in the progress notes over the six month period in 2015, no DOS charting was found.

A review of the home’s policy titled “Responsive Behaviour Program - N-R13”, last revised on January 2015, indicated that a DOS was to be completed whenever there was a change or concern about a resident’s behaviours. The completed DOS tool was to be placed into the resident’s chart with a note placed on the care plan that the resident was being monitored with the tool. Additionally, this policy identified that a behavioural assessment tool was to be completed by registered staff within seven days of admission to the home and quarterly thereafter.

Inspector #621 reviewed resident #008’s documentation for completion of a behavioural assessment tool quarterly for the six month period in 2015, as per the home’s policy and no completed behavioural assessments were found.

The Inspector also reviewed the most current written care plan for resident #008 located at the nursing unit which identified a number of interventions to mitigate responsive behaviours. However, no documentation was found in the resident’s plan of care to identify whether the care planned interventions were reviewed or reassessed.

During an interview on June 23, 2016, with the Nurse Manager #103, they reported to Inspector #621 that due to the number and severity of responsive behaviours demonstrated by resident #008, it was their expectation that in order to respond to the needs of resident #008 DOS charting had been completed daily, a behavioural assessment was completed at least quarterly, and staff were reviewing and reassessing the care plan to ensure interventions documented were current and effective in managing this resident’s responsive behaviours.

On review of documentation for resident #008, Nurse Manager #103 verified that DOS charting had not occurred when 27 incidents of responsive behaviours were identified in the progress notes. They also determined that no behavioural assessment had been completed quarterly as per the home’s policy either in paper copy or electronically during this time period to respond to the needs of the resident, and should have. [s. 53. (4) (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 when resident #008 demonstrates responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions were documented, to be implemented voluntarily.

WN #7: 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 maintained in a safe condition and in a good state of repair.

Inspector # 617 observed resident #004 seated in a specific type of chair in their room with both arm rests of the chair visibly worn with the vinyl torn and foam under pad exposed.

On June 21, 2016, Inspector #621 reviewed a preventative maintenance program report dated from June 2016, which identified a list of assistive devices used with each resident in the home. This report listed resident #004 to have a different chair, not the observed type of chair as an assistive device.

During an interview with Nurse Manager #103, they reported to Inspector #621 that the home had just started preventative maintenance on residents' assistive devices which included walkers, wheelchairs and specific chairs, and the first audit and report as provided to Inspector #621 was completed in June 2016.

The Nurse Manager #103 and Inspector #621 went to resident #004’s room and found the specific chair. They observed that the vinyl of both arm rests was split on each rest and exposed the foam under pad. Nurse Manager #103 identified that this resident had used this specific chair for the past six weeks and no longer used a different type of chair due to a change in the resident’s condition. Nurse Manager #103 identified that the maintenance audit did not include an inspection of resident #004’s specific chair and should have. Additionally, Nurse Manager #103 confirmed that this resident's specific chair was not in a state of good repair as it had worn arm rests with vinyl upholstery splitting and exposing the foam under pad. [s. 15. (2) (c)]

WN #8: 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 ensure that a person who had reasonable grounds to suspect that abuse or neglect occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

During a review of resident #008's progress notes Inspector #621 identified a note in 2015, reporting an incident of alleged sexual touching between resident #008 and #012. The note indicated that RPN #107 and RPN #108 witnessed the incident. RPN #108 documented that they attempted to intervene, but then called on additional staff from the hospital to assist as resident #008 was known to demonstrate responsive behaviours. Documentation by RPN #108 indicated that after several requests from staff, resident #008 removed his hand away from resident #012 and then residents were able to be separated.

During an interview with Nurse Manager #103 on June 22, 2016, they reported to Inspector #621 that they were not aware of this incident as it occurred during the time when a previous Nurse Manager #106 had worked in the position. Nurse Manager #103 identified that an internal investigation had been completed regarding this incident.

Inspector #621 reviewed the home's internal incident report filed by RPN #108 detailing the incident. Notification of the incident was made to the previous Nurse Manager #106. Both the previous Nurse Manager #106 and the Chief Nursing Officer signed the incident

report acknowledging its receipt.

Inspector #621 reviewed the Critical Incident System (CIS) for reports submitted to the Director by the home between the date of the incident over a 16 month period to June, 2016, and found no CI submitted by the home for the incident.

A review of the home's policy titled "Workplace Violence & Harassment - Resident Abuse - #WVHP-11", last revised October 2013, identified under the procedures section that all abuse must be reported to the Ministry of Health and Long-Term Care (MOHLTC).

During an interview with Nurse Manager #103, they reported to Inspector #621 that it was their expectations that this incident of sexual behaviour documented in the progress notes between resident #008 and #012 was to be investigated and reported to the MOHLTC as per legislative requirements. On review of the CIS, Nurse Manager #103 indicated that they could not find evidence that this incident had been reported to the Director.

In a previous inspection report #2015_433625_0007, Compliance Order (CO) #003 was issued to the home on February 19, 2016, with a compliance date of April 15, 2016. This incident occurred prior to the compliance date. [s. 24. (1)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee has failed to ensure that they consulted regularly with Residents' Council, and in any case, at least every three months.

A review of the Resident Council minutes provided from the home over the previous 12 months identified three meetings which were held on June 29, 2015, March 26, 2016 and May 30, 2016.

During an interview with the President of Residents' Council, they identified to Inspector #621 that meetings of Resident Council occurred sporadically with two meetings in the past 3 months of this year, and more than an eight month gap between the June 2015 meeting and March 2016 meeting.

During an interview with the Recreation Aide #123, they reported to Inspector #621 that they provide assistance to Residents' Council in preparing, conducting and following up on business of Residents' Council meetings, and confirmed that the home had not consulted with Residents' Council at least every three months as per legislative requirements. [s. 67.]

Issued on this 22nd day of September, 2016

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHEILA CLARK (617), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2016_339617_0023
Log No. / Registre no:	011643-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 21, 2016
Licensee / Titulaire de permis :	GERALDTON DISTRICT HOSPITAL 500 HOGARTH AVENUE WEST, GERALDTON, ON, P0T-1M0
LTC Home / Foyer de SLD :	GERALDTON DISTRICT HOSPITAL 500 HOGARTH AVENUE WEST, GERALDTON, ON, P0T-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lucy Bonanno

To GERALDTON DISTRICT HOSPITAL, 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_433625_0007, 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 :

Train all staff working on, or having responsibility for, the long term care unit on the home's revised abuse and neglect policies.

Grounds / Motifs :

1. The licensee failed to protect residents from abuse by anyone and ensure that residents were not neglected by the licensee or staff by not complying with previously issued compliance order (CO) #001.

Previous Inspection #2015_433625_0007 issued the home CO #001 pursuant to LTCHA, S. O. 2007, s 19 (1), on February 19, 2016. The home was to be compliant by April 15, 2016, regarding the following orders from the Inspector:

a) Review and revise all policies related to resident abuse and neglect to ensure that they are in compliance with the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

b) Train all staff working on, or having responsibility for, the long-term care unit on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10.

c) Develop and implement a system to monitor compliance with the home's abuse and neglect policies.

d) Develop and implement a system to ensure that staff are familiar with the

current care plans for each patient and resident they provide care to including, but not limited to, interventions to address harmful or potentially harmful interactions.

e) Immediately report to the Director all incidents of alleged, suspected or witnessed abuse.

f) Immediately notify the appropriate police force of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

g) Notify the resident's Substitute Decision Maker (SDM) immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of a resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and notify the SDM within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

In relation to item "b" under compliance order #001, Inspector #617 found that staff working on, or having responsibility for, the long-term care unit were not trained on the revised abuse and neglect policies, specifically related to abuse prevention, recognition, response, and reporting requirements as identified in the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10, at the time of the inspection.

In June, 2016, Inspector #617 interviewed the following staff members who reported that they had not been trained in the revised abuse and neglect policies related to abuse prevention, recognition, response and reporting requirements: HSK #118, HSK #119, Kitchen Staff #120, and Anishnawbe Resource Worker #121.

During interviews with Nurse Manager #103, the Chief Nursing Officer, and the Staff Educator, it was confirmed to the Inspector that not all staff have been trained in the revised non-abuse policies. It was explained that the home had planned the training in four phases. The first phase was completed where all direct care staff including the PSWs and the RPNs were trained. Phase two, three and four had not yet been scheduled which involved the support staff in housekeeping, dietary, maintenance, the Anishnawbe Resource Worker,

Recreation Aides, RNs, and Volunteers.

The decision to issue an order was based on potential for actual harm of a pattern of residents exposed to abusive situations and a previously issued Compliance Order (CO) specific to LTCHA 2007, S. O. 2007, s 19 (1). This inspection found that the home did not meet the requirements set out in the Inspector's orders for compliance by April 15, 2016.

There was a history of previous non-compliance under this legislation identified during the following inspection:
-CO #001 was issued in Critical Incident System Inspection #2015_433625_0007, served to the home on February 19, 2016. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_433625_0007, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The Licensee shall:

Train all staff in the areas of the Residents' Bill of Rights, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

Grounds / Motifs :

1. The licensee has failed to comply with previously issued compliance order (CO) #004, staff training and re-training.

Previous Inspection #2015_433625_0007 issued the home CO #004 pursuant to LTCHA, S. O. 2007, s 76 (4), on February 19, 2016. The home was to be compliant by April 15, 2016, regarding the following orders from the Inspector:

a) Provide training to all staff in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

b) Provide training to all staff prior to performing their responsibilities, annually and at any other time determined necessary by the licensee in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

c) Evaluate the knowledge of staff post-training and ensure that staff demonstrate knowledge and understanding of the content.

d) Maintain records of the training provided including, but not limited to, dates, times, attendees, trainers, materials taught and post-training staff evaluations.

In relation to item "a" under CO #004, Inspector #617 found that training was not provided to all staff in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26.

In June, 2016, Inspector #617 interviewed the following staff members who reported that they had not been trained in the areas of the Residents' Bill of Rights, the home's revised policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections afforded by section 26: HSK #118, HSK #119, Kitchen Staff #120, and Anishnawbe Resource Worker #121.

During interviews with Nurse Manager #103, the Chief Nursing Officer, and the Staff Educator, it was confirmed to the Inspector that not all staff had been trained in the in the areas of the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports and the whistle-blowing protections. The Staff Educator explained that the home had planned the training in four phases. The first phase was completed where all direct care staff including the PSWs and RPNs were trained. Phase two, three and four had not yet been scheduled which involved staff in housekeeping, dietary, maintenance, the Anishnawbe Resource Worker, Recreation Aides, RNs, and Volunteers.

The decision to issue an order was based on a previously issued Compliance Order (CO) specific to LTCHA 2007, S.O. 2007, s. 76 (4). This inspection found that the home did not meet the requirements set out in the Inspector's orders for compliance by April 15, 2016. There was a history of previous non-compliance under this legislation identified during the following inspection:

-CO #004 was issued in Critical Incident System inspection #2015_433625_0007, served to the home on February 19, 2016. (617) (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 14, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 21st day of September, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sheila Clark

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