Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2017	2017_652625_0014	016993-17	Resident Quality Inspection

Licensee/Titulaire de permis

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET P.O. BOX 190 HORNEPAYNE ON P0M 1Z0

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

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET P.O. BOX 190 HORNEPAYNE ON P0M 1Z0

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

KATHERINE BARCA (625), LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 22 to 25, 2017.

An additional intake completed during the Resident Quality Inspection (RQI), log #033279-16, was related to a Follow-up to Compliance Order #001 issued during inspection #2016_269627_0021 regarding Ontario Regulation 79/10, s. 8 (1) (b) complying with the home's policy to minimize the restraining of residents.

During the course of the inspection, the inspector(s) spoke with residents, families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD), the Manager of Dietary, Plant and Domestic Services, the Activity Coordinator, the Long-Term Care (LTC) Manager and the Chief Executive Officer (CEO).

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspectors also reviewed relevant health care records, council meeting minutes, nursing meeting minutes, incident reports and numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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, 2007 S.O. 2007, c. 8 or Ontario Regulation 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was in compliance with and was implemented in accordance with all applicable requirements under the Act.

During resident observations by Inspector #625 on a date in August 2017, residents #004 and #005 were identified as using potential safety devices.

During an interview with Inspector #625 on a date in August 2017, the Director of Care (DOC) stated that the home's program titled "Least Restraint Program" dated June 2017, was the current program in use.

A review of the home's program titled "Least Restraint Program" dated June 2017, identified the following inaccurate references to the Long-Term Care Homes Act (LTCHA), 2007 S.O. 2007, c. 8:

(1) Page three of the home's program read "If the resident is able to release the restraint independently – that is, the resident understands how to release the device and is physically able to do so, the device is not considered a restraint. However, if the resident must struggle, takes an extended period of time to remove the device, or is inconsistent, he or she is considered to be restrained with a physical device (LTCH [sic] s. 30 (5))."

The program's reference to the LTCHA, 2007 S.O. 2007, c. 8, s. 30 (5) was inaccurate as that legislation states "The use of barriers, locks or other devices or controls at

entrances and exits to the home or the grounds of the home is not a restraining of a resident unless the resident is prevented from leaving. 2007, c. 8, s. 30 (5).” and does not contain the content identified in the home's program. The LTCHA, 2007, c. 8, s. 30 (2) identifies that "The use of a physical device from which a resident is both physically and cognitively able to release themself is not a restraining of the resident". However, the legislation does not identify the specific criteria such as struggling, taking an extended period of time to remove the restraint or being inconsistent in the removal of the restraint as factors to consider when qualifying a device as a restraint.

During a phone interview with Inspector #625, the LTC Manager stated that the content identified on page three of the home's program did not reflect the content contained in the cited reference to the LTCHA, 2007, S.O. 2007, s. 30 (5).

(2) Page four of the home's program read “Environmental Restraints (LTCHA s.32) Any device or barrier that limits the movement of an individual, and thereby confines an individual to a specific geographic area or location (e.g. secured units, wander-guard systems). The use of barriers, locks and other devices or controls at stairways as a safety, [sic] measure is not a restraining of a resident.”

The LTCHA, 2007 S.O. 2007, c. 8, s. 32 does not contain the content identified in the home's program and has not yet come into force. The LTCHA, 2007 S.O. 2007, c. 8, s. 30 (6) states "The use of barriers, locks or other devices or controls at stairways as a safety measure is not a restraining of a resident." The legislation does not contain the content identified in the first sentence quoted regarding environmental restraints.

During a phone interview with Inspector #625, the LTC Manager acknowledged that the LTCHA, 2007 S.O. 2007, c. 8, s. 32 has not yet come into force as was noted directly above s. 32 in the Act.

(3) Page four of the home's program read “Chemical Restraints (LTCHA s. 36 (3-4)) Pharmaceuticals given with the specific and sole purpose of inhibiting specific behaviour or movements. Differentiating between the use of a drug as a therapeutic agent or a restraint is difficult. However, when a drug is used to treat clear-cut, psychiatric or medical symptoms, it is not usually considered a restraint.”

The LTCHA, 2007 S.O. 2007, c. 8, s. 36 addresses the common law duty "of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 2007, c. 8, s. 36 (1)". Subsection (3) states “A

resident may not be restrained by the administration of a drug pursuant to the common law duty described in subsection (1) unless the administration of the drug is ordered by a physician or other person provided for in the regulations. 2007, c. 8, s. 36 (3)." and subsection (4) states "If a resident is being restrained by the administration of a drug pursuant to the common law duty described in subsection (1), the licensee shall ensure that the drug is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36 (4)." Neither subsection contains the content regarding chemical restraints identified in the home's program.

During a phone interview with Inspector #625, the LTC Manager acknowledged that the home's program referencing s. 36 (3) and (4) did not represent what the Act contained regarding the common law duty.

(4) Page five of the home's program reads "The resident's care plan must indicate what, when and why the device is to be used. The care plan must indicate the removal of the device as soon as no longer needed to promote independence. When a PASD is being used to restrain a resident rather than to assist the resident with routine activity of living, it is considered a restraining device and the requirements for restraining by use of a physical device apply (LTCHA s36(6) & s.31)."

The LTCHA, 2007 S.O. 2007, c. 8, s. 36 does not contain subsection (6).

The LTCHA, 2007 S.O. 2007, c. 8, s. 31 (1) addresses that, a resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31 (1). Subsection (2) then identifies specific, detailed criteria that must be satisfied for restraining to be included in a resident's plan of care, not care plan, and requires more criteria be included than "what, when and why the device is to be used" as is listed in the program. Subsection (3) further details requirements if a resident is restraint by a device under subsection (1). None of the subsections contain the content identified in the home's program. The Act does state, under s. 33 (6) "For greater certainty, if a PASD is being used to restrain a resident rather than to assist the resident with a routine activity of living, section 31 applies with respect to that use instead of this section. 2007, c. 8, s. 33 (6)"

During a phone interview with Inspector #625, the LTC Manager acknowledged that s. 36 (6) was not present in the legislation and any reference to it was incorrect. The Manager

also acknowledged that the content represented in the policy citing specific references in the LTCHA, 2007, S.O. 2007, c. 8 did not represent the actual content in the Act and that the sections of the home's program identified were not in compliance with the sections of the Act that they were referencing. [s. 8. (1) (a)]

2. The licensee has failed to ensure that compliance order (CO) #001 regarding the home's completion of restraint assessment forms, issued in inspection #2016_269627_0021, was complied with. The home specifically failed to comply with part two of the order.

The compliance order, due November 30, 2016, required the licensee to ensure that the home's restraint policy was complied with by ensuring that:
(1) All residents admitted to the long-term care home had a restraint assessment done using the "Interdisciplinary Restraint Assessment Form";
(2) Any restraints that were implemented for a resident, were reassessed and documented by the interdisciplinary team at least quarterly on the "Interdisciplinary Restraint Assessment Form"; and
(3) Restraints were not used as a first step in management of a resident's safety, but rather as part of a graduate set of interventions which should be documented.

Inspector #625 reviewed the home's policy in place at the time of inspection #2016_269627_0021 until May 2017, titled "Physical/Chemical/Environmental Restraints" (undated), which identified that "all clients admitted to Long Term Care with restraints [were] assessed using the interdisciplinary restraint assessment form" and "restraints [were] reassessed and documented by the interdisciplinary team at least quarterly on the Interdisciplinary Restraint Assessment Form".

On a date in August 2017, Inspector #625 reviewed resident #004's and resident #005's charts and identified a "Longterm [sic] Care Interdisciplinary Physical Restraint Assessments" dated on a date in the spring of 2015, and a date in the fall of 2016, respectively. The Inspector could not locate any other "Longterm Care Interdisciplinary Physical Restraint Assessments" completed for either resident.

During interviews with the Long-Term Care (LTC) Manager on dates in August 2017, they stated that the "Longterm Care Interdisciplinary Physical Restraint Assessments" dated on a date in the spring of 2015, and on a date in the fall of 2016, were the only assessments of their kind on resident #004's and #005's charts, respectively, as that assessment had only been completed on admission and not at any other time. The

Manager stated that the home's restraint policy in place prior to May 2017, "Physical/Chemical/Environmental Restraints" (undated) indicated that the "Longterm Care Interdisciplinary Physical Restraint Assessment" was to be used on admission and quarterly. The Manager also stated that, beginning in the fall of 2016, the home had used restraint assessments in Point Click Care (PCC) and not the "Longterm Care Interdisciplinary Physical Restraint Assessment" and in June 2017, the home had implemented a new minimizing of restraining program titled "Least Restraint Program".

To determine if the home had completed any appropriate initial assessments or quarterly reassessments of restraints implemented for residents since the compliance due date, the Inspector reviewed the home's current minimizing of restraining policies and completion of restraint assessments in PCC.

The Inspector's review of the home's current policy titled "Least Restraint Policy - LTC" operational date February 5, 2017, identified that "The policy of this Hospital is: The Least Restraint Program is to be followed".

The Inspector also reviewed the home's current program titled "Least Restraint Program" effective June 2017, that indicated "Current needs are determined through on-going assessment by the interdisciplinary team" and that registered staff "completes a thorough assessment within 24 hours of admission". The program did not specify the specific assessment(s) to be completed on admission, when restraints were implemented or quarterly, and did not refer to the restraint assessments in PCC.

On a date in August 2017, Inspector #625 reviewed resident #004's chart and located an "Initial Assessment for Use of Physical Restraint" dated on a date in the winter of 2017, and two "Quarterly Review for Use of Physical Restraint" dated the spring and summer of 2017, completed for the resident in PCC. Neither "Quarterly Review for Use of Physical Restraint" identified the type of restraints being reviewed and in use.

On a date in August 2017, Inspector #625 reviewed resident #005's chart and located an "Initial Assessment for Use of Physical Restraint" dated on a date in the fall of 2016, and two "Quarterly Review for Use of Physical Restraint" dated the winter and spring of 2017, in PCC. Neither "Quarterly Review for Use of Physical Restraint" identified that the resident used a specific restraint in use and the assessment completed in the spring of 2017 was blank and had not been completed.

During an interview with the Resident Assessment Instrument (RAI) Coordinator on a

date in August of 2017, they confirmed that the "Quarterly Review for Use of Physical Restraint" dated on a date in the spring of 2017, for resident #005 was blank and had not been completed.

The home has failed to comply with CO #001 as the home did not, for any of the restraints that were in use by residents #004 and #005, or for any of the restraints in use in the home, ensure the restraints were reassessed and documented, by the interdisciplinary team, at least quarterly on the "Longterm Care Interdisciplinary Physical Restraint Assessment". In addition, the home did not complete a quarterly review of resident #005's restraint use using any restraint assessment form. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a skin and wound care program to promote skin

integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was developed and implemented in the home.

On a date in August 2017, Inspector #196 observed altered skin integrity on resident #003's body.

During an interview with Inspector #196 on a date in August 2017, the LTC Manager of the home reported that a skin and wound care program had not been implemented in the home. [s. 48. (1) 2.]

2. The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #004 was at risk for, or had, altered skin integrity.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Quality Improvement and Required Programs" completed by the home on August 23, 2017. The home had responded affirmatively, that the interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was developed and implemented in the home.

On August 24, 2017, during a review by Inspector #625 of "Nursing Meeting" minutes dated May 30, 2017, it was identified that the home did not have three required programs developed and implemented, including a skin and wound care program.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager clarified that the home did not have a skin and wound care program in place. [s. 48. (1) 2.]

3. The licensee has failed to ensure that an interdisciplinary continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable was developed and implemented in the home.

The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #005 used a device related to elimination.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Quality Improvement & Required Programs" completed by the home. The home has responded affirmatively, that the interdisciplinary continence care and bowel management program

to promote continence and to ensure that residents were clean, dry and comfortable, was developed and implemented in the home.

Inspector #625 reviewed the "Nurse Meeting" minutes dated May 30, 2017, that identified that the home did not have a continence care and bowel management program in place but that it was a mandatory program.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager clarified that a continence care and bowel management program had not yet been developed and implemented in the home. [s. 48. (1) 3.]

4. The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #004 used a device related to elimination.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager stated that a continence care and bowel management program had not yet been developed or implemented in the home. [s. 48. (1) 3.]

5. During a staff interview with Inspector #196, it was identified that resident #001 used a device related to elimination.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager stated that a continence care and bowel management program had not yet been developed or implemented in the home. [s. 48. (1) 3.]

6. The licensee has failed to ensure that an interdisciplinary pain management program to identify pain in residents and manage pain was developed and implemented in the home.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Quality Improvement and Required Programs" completed by the home on August 23, 2017. The home had responded affirmatively, that the interdisciplinary pain management program to identify pain in residents and manage pain, was developed and implemented in the home.

On a date in August 2017, during a review by Inspector #625 of "Nursing Meeting" minutes dated May 30, 2017, it was identified that the home did not have three required programs developed and implemented, including a pain management program.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager clarified that a pain management program had not yet been developed and implemented in the home. [s. 48. (1) 4.]

Additional Required Actions:

CO # - 002, 003, 004 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).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #005 used a device related to elimination.

On August 24, 2017, Inspector #625 reviewed the home's policy provided by the LTC Manager titled "Indwelling Catheter Care for LTC Residents" operational date February 1, 1996, with no revision date listed. The policy identified that "Indwelling catheters and catheter collection bags are changed once per month in LTC".

On a date in August 2017, Inspector #625 reviewed resident #005's current care plan with a focus on the device related to elimination. The care plan identified that the resident had an a specific size and type of device and required a certain treatment related to the device at a specific frequency on a specific date.

A review of the resident's chart on a date in August 2017, included the resident's a physician's order dated a date in the fall of 2016, for a treatment related to the a specific size and type of device at a different specific frequency, which was the most recent physician's order related to the resident's device.

A review of resident #005's Medication Administration Records (MARs) identified entries to provide a treatment for the specific size and type of device at a specific frequency as follows:
- During one month in 2017, the treatment was scheduled on a specific date of that month;
- During the next month in 2017, the treatment was scheduled on a different specific date of that month (a certain number of days after it was completed the previous month);
- During the next month in 2017, the treatment was scheduled on the a different specific date of that month (a certain number of days after it was completed the previous month); and
- During the next month in 2017, the MAR listed that the treatment was scheduled on a different specific date of that month (a different number of days after if was completed the previous month).

During an interview with RPN #104 on a date in August 2017, they stated that staff performed a treatment involving resident #005's device at a specific frequency. They acknowledged that the MAR entries indicated that treatment was to occur at a different specific frequency while the care plan indicated it was to occur on a specific date.

During an interview with the RAI Coordinator on a date in August 2017, they stated that they had initiated and updated the resident's care plan and entered the information for treatment involving the device on a specific date based on the physician's order for a

specific date in the fall of 2016. The RAI Coordinator stated that the staff who performed the treatment would be unclear as to when they were to be done as the dates and frequency of the treatments listed in the resident's plan of care conflicted.

During an interview with the LTC Manager on a date in August 2017, they stated to Inspector #625 that, if the care plan indicated resident #005’s treatment was to be completed on a specific date, but that the MAR indicated it was to be completed at a specific frequency as well as at a different specific frequency on another specific date, the plan of care did not provide clear direction to staff as to when the treatment was to be completed. [s. 6. (1) (c)]

2. During a staff interview with Inspector #196 on a date in August 2017, it was identified that resident #002 had no plan in place to address a specific condition.

On a date in August 2017, Inspector #196 observed resident #002 eating a meal consisting of food served in a specific manner.

Inspector #196 reviewed documents related to resident #002's plan of care with a focus on nutritional interventions including:
- The "Long Term Resident Menu" which identified the diet for resident #002 as one type of diet and identified the resident's likes and dislikes related to the diet;
- A physician's order sheet dated a date in the spring of 2017, that listed a specific type of diet;
- A Meditech generated diet list used by the home that did not identify the type of diet to be provided to resident #002; and
- The current care plan dated a date in the spring of 2017, that indicated a specific type of diet.

Inspector #196 interviewed PSW #105 who indicated the "Long Term Resident Menu" listed a type of diet, as well as another type of diet and a third instruction related to the type of diet. The PSW stated that the resident was provided with a specific type of diet from the kitchen and that the diet for resident #002 listed on the menu was confusing and hard to understand.

During an interview with the Manager of Dietary, Plant and Domestic Services on a date in August of 2017, they reported to Inspector #196 that resident #002's meal should have been provided to the resident in a specific manner as the resident was to receive a specific type of diet and that the kitchen was to provide this diet modification.

During a telephone interview with Inspector #196 on a date in August of 2017, the Registered Dietitian (RD) reported that a specific type of diet was to be served using a specific device, with characteristics between two other specific diet types, which was more modified than the food the Inspector observed provided to the resident. [s. 6. (1) (c)]

3. The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #004 used a device related to elimination.

On August 24, 2017, Inspector #625 reviewed resident #004's current care plan with a focus on the use of a device related to elimination. The care plan identified that the resident had a treatment related to a specific size and type of device at a specific frequency on a specific date.

A review of the resident's chart on a date in August 2017, included an order dated a date in the fall of 2016, to provide a treatment related to the device, which was the most recent order related to treatment. The order did not identify the type of device to use or the frequency of future treatments.

A review of resident #004's Medication Administration Records (MARs) identified entries to provide the treatment related to a specific size and type of device at a specific frequency as follows:
- During one month in 2017, the treatment was scheduled on a specific date;
- During the next month in 2017, the treatment was scheduled on the a different specific date (a certain number of days after it was completed the previous month) and was also completed on a second specific date that month;
- During the next month in 2017, the treatment was scheduled on the a different specific date (a different number of days after it was completed the previous month); and
- During the next month in 2017, the treatment was scheduled on a different specific date (a different number of days after it was completed the previous month).

During an interview with the RAI Coordinator on a date in August 2017, they stated that they had initiated and updated the resident's care plan and entered the information for treatment related to the specific size and type of device at a specific frequency on a specific date based on the physician's order. The RAI Coordinator acknowledged that, although the current care plan indicated a treatment related to a specific size and type of device was to be completed at a specific frequency on a specific date, the four most

recent MARs indicated a different sized device on different dates of each month, none of which was the date specified in the care plan. The Coordinator stated the plan of care did not provide clear direction to staff on what size of device to use and the frequency or date of required treatments.

During an interview with the LTC Manager on a date in August 2017, they stated to Inspector #625 that, if the care plan indicated a treatment involving resident #004's device was to occur at a specific frequency on a specific date, but that the MARs indicated that treatments were to be completed on different specific dates, the plan of care did not provide clear direction to staff on when the treatment related to the device was to occur. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

During a staff interview with Inspector #196 on a date in August 2017, it was identified that resident #001 had no plan in place to address a specific condition.

On a date in August 2017, Inspector #196 reviewed the health care records of resident #001 with a focus on specific interventions including:
- The most recent Registered Dietitian (RD) assessment dated a date in the summer of 2017, that noted that resident #001 had continued to exhibited a specific characteristic with the recommendation for specific interventions related to the resident's diet; and
- The current physician's orders, care plan and "Long Term Resident Menu", each of which did not identify the provision of a specific intervention recommended by the RD.

During interviews with Inspector #196, RN #110 and PSW #105 indicated that resident #001 was not receiving the specific intervention recommended by the RD.

The Inspector reviewed the home's policy titled "Nutrition Care", last reviewed/revised May 2015, that indicated the nutrition care program included "providing residents with nutritional supplements according to assessed needs".

The Inspector also reviewed the home's policy titled "Diet Orders", reviewed/revised May 2015, that identified the objective "to ensure accuracy of meals provided, all diet orders, including any changes, are communicated in writing to Nursing and Dietary Departments,

by whoever processes the change." The policy also indicated that "All changes to diet orders are prescribed by the Registered Dietitian or the Physician and documented in the resident's chart and in the Nutrition Care Plan as well as in the Dietary servery Kardex."

During an interview with the Manager of Dietary, Plant and Domestic Services, they stated that the change in the diet order should have been entered into the computer on Meditech to communicate the change.

During a phone interview with Inspector #625 on a date in September 2017, the LTC Manager stated to Inspector #625 that the home used the electronic Meditech program to process changes in diet orders.

An interview with Inspector #196 was conducted with the RD on a date in August 2017, where they reported that they had called the kitchen on a date in July 2017, and informed them of the recommendation for the recommended intervention. The RD stated that they thought the physician was required to write an order for the intervention that the kitchen staff or nursing staff would get that order and that there would be a record of the intervention in the computer. The RD stated that they were unaware that the resident had not been receiving the recommended intervention. [s. 6. (4) (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 that ensures that:
- there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and
- the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #4: 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 the resident, the resident's substitute decision-maker, if any, and any person that either of them may have directed were given an opportunity to participate fully in the care conferences.

During a family interview with Inspector #625 on a date in August 2017, resident #005's substitute decision-maker (SDM) #111 stated that they had not been involved or invited to an admission care conference six weeks following resident #005's admission to the home.

A review of resident #005's health care record by Inspector #625 on a date in August 2017, identified that the resident's SDM was SDM #111 and that the resident was admitted to long-term care on a date in 2016.

During an interview with the LTC Manager on a date in August 2017, they stated that the home did not hold admission care conferences within six weeks following residents' admission or annually. They stated that the resident or the SDM had not been invited to attend any care conferences. [s. 27. (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 that ensures that 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 admission and annual care conferences, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 has failed to ensure that, if there was no Family Council, semi-annual meetings were convened to advise residents' families and persons of importance to residents of the right to establish a Family Council.

During an interview with Inspector #625 on a date in August 2017, the RAI Coordinator stated that the home did not have a Family Council in place but that the Activity Coordinator was assigned to support a Family Council, should one be established, and would likely have records of recruitment efforts.

During an interview with the Activity Coordinator on a date in August 2017, they stated to the Inspector that there was no Family Council established in the home, and there had not been one in the home since the LTCHA, 2007 S.O. 2007, c. 8 had taken effect. They stated that the home had convened a meeting regarding the Family Council during the summer of 2016, during a barbecue, but that semi-annual meetings had not been convened to advise persons of the right to establish a Family Council from 2010 to present.

Inspector #625 reviewed the home's invitation regarding the "Family Council BBQ" that identified a barbecue was held in honour of Family Council week on June 8, 2016.

During an interview with the LTC Manager on a date in August 2017, they stated that, since the Act had come into effect in 2010, the home had not convened semi-annual meetings to advise people of their right to establish a Family Council. [s. 59. (7) (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 that ensures that, if there is no Family Council, the licensee convenes semi-annual meetings to advise advise residents’ families and persons of importance to residents of the right to establish a Family Council, to be implemented voluntarily.

WN #6: 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 LTCHA, 2007, S.O. 2007, c.8 dealt with how the use of restraining in the home would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and Ontario Regulation 79/10.

During resident observations by Inspector #625 on a date in August 2017, residents #004 and #005 were identified as using potential safety devices.

Inspector #625 reviewed the home's policy titled "Lease Restraint Policy – LTC" operational date Feb 5, 2017, that indicated the home's "Least Restraint Program" was to be followed.

During a review of the home's program titled "Least Restraint Program" dated June 2017, Inspector #625 was not able to locate how the use of restraining in the home would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and Regulation.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager stated that the home's written "Least Restraint Program" dated June 2017, did not identify how the use of restraining in the home would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and Regulation. [s. 109. (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the home's written policy under section 29 of the Act deals with 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 #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including that access to all areas where drugs were stored was restricted to persons who may dispense, prescribe or administer drugs in the home and to the Administrator.

During the observation of medication administration on a date in August 2017, RPN #104 stated to Inspector #196 that the housekeeping staff were aware of the entrance code to gain entry to the locked medication room.

During an interview with Housekeeping Aide #112 on a date in August 2017, they stated to Inspector #196 that they knew the code to enter the locked medication room and used the code to empty the garbage and clean the room. The Housekeeping Aide confirmed that they were not a registered staff member and were not able to dispense, prescribe or administer drugs in the home.

During a review of the medication policies related to the security of the home's drug supply, Inspector #196 reviewed the home's policy titled "Medication Cart" effective January 25, 1996, that stated the code for the medication cart.

On a date in August 2017, during an interview with Inspectors #196 and #625, RPN #104 confirmed that the access code to the medication cart was listed in the home's policy and was accessible to unregistered staff.

During an interview regarding the security of the home's drug supply with the LTC Manager on a date in August 2017, they stated to Inspectors #196 and #625 that only the registered nursing staff were to have access to the medication room and know the code to the unlock the medication cart. They further stated that the code to the medication cart had not been changed for at least seven years despite the potential for former employees who no longer worked in the home to recall the code. The Manager also stated that they did not know who had originally programmed the code into the medication cart and that the Maintenance Department may also know the code for the medication cart, if they had originally programmed it. [s. 130. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that steps are taken to ensure the security of the drug supply, including restricting access to all areas where drugs are stored to persons who may dispense, prescribe or administer drugs in the home and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the pharmacy service provider.

Inspector #196 reviewed medication incident reports involving residents including:
- A report dated a date in the winter of 2017, that identified resident #004 was incorrectly administered a medication. The report contained no notation that the pharmacy was notified of the incident;
- A report dated a date in the spring of 2017, that identified that medication was not signed as administered and the specific medication count did not reflect that medication had been given to a resident. The report contained no notation that the pharmacy was notified of the incident; and
- A report dated a date in the spring of 2017, that identified a medication was administered to resident #006 instead of a different medication. The report contained no notation that the pharmacy was notified of the incident.

During an interview with Inspector #196 on a date in August 2017, the LTC Manager stated that the pharmacy service provider had not been notified of medication incidents and had no involvement in the analysis or review of the medication incidents. [s. 135. (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 that ensures that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

Issued on this 1st day of December, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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) :	KATHERINE BARCA (625), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2017_652625_0014
Log No. / No de registre :	016993-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 27, 2017
Licensee / Titulaire de permis :	HORNEPAYNE COMMUNITY HOSPITAL 278 FRONT STREET, P.O. BOX 190, HORNEPAYNE, ON, P0M-1Z0
LTC Home / Foyer de SLD :	HORNEPAYNE COMMUNITY HOSPITAL 278 FRONT STREET, P.O. BOX 190, HORNEPAYNE, ON, P0M-1Z0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Jaremy-Berube

To HORNEPAYNE COMMUNITY 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: 2016_269627_0021, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that:

(1) The home's written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with Long-Term Care Homes Act (LTCHA), 2007 S.O. 2007, c. 8 and Ontario Regulation 79/10 is in compliance with the Act and Regulation;

(2) Any restraints that are implemented or are in use in the home are assessed upon initiation of the restraint and reassessed quarterly by the interdisciplinary team and the assessment is documented using an appropriate assessment instrument that is specifically identified in the home's minimizing of restraining policy; and

(3) All residents currently in the home who use restraints have current assessments completed for the use of each restraint that meet the requirements of the Act and Regulation.

Grounds / Motifs :

1. The licensee has failed to ensure that compliance order (CO) #001 regarding the home's completion of restraint assessment forms, issued in inspection #2016_269627_0021, was complied with. The home specifically failed to comply

with part two of the order.

The compliance order, due November 30, 2016, required the licensee to ensure that the home's restraint policy was complied with by ensuring that:
(1) All residents admitted to the long-term care home had a restraint assessment done using the "Interdisciplinary Restraint Assessment Form";
(2) Any restraints that were implemented for a resident, were reassessed and documented by the interdisciplinary team at least quarterly on the "Interdisciplinary Restraint Assessment Form"; and
(3) Restraints were not used as a first step in management of a resident's safety, but rather as part of a graduate set of interventions which should be documented.

Inspector #625 reviewed the home's policy in place at the time of inspection #2016_269627_0021 until May 2017, titled "Physical/Chemical/Environmental Restraints" (undated), which identified that "all clients admitted to Long Term Care with restraints [were] assessed using the interdisciplinary restraint assessment form" and "restraints [were] reassessed and documented by the interdisciplinary team at least quarterly on the Interdisciplinary Restraint Assessment Form".

On a date in August 2017, Inspector #625 reviewed resident #004's and resident #005's charts and identified a "Longterm [sic] Care Interdisciplinary Physical Restraint Assessments" dated on a date in the spring of 2015, and a date in the fall of 2016, respectively. The Inspector could not locate any other "Longterm Care Interdisciplinary Physical Restraint Assessments" completed for either resident.

During interviews with the Long-Term Care (LTC) Manager on dates in August 2017, they stated that the "Longterm Care Interdisciplinary Physical Restraint Assessments" dated on a date in the spring of 2015, and on a date in the fall of 2016, were the only assessments of their kind on resident #004's and #005's charts, respectively, as that assessment had only been completed on admission and not at any other time. The Manager stated that the home's restraint policy in place prior to May 2017, "Physical/Chemical/Environmental Restraints" (undated) indicated that the "Longterm Care Interdisciplinary Physical Restraint Assessment" was to be used on admission and quarterly. The Manager also stated that, beginning in the fall of 2016, the home had used restraint assessments in Point Click Care (PCC) and not the "Longterm Care

Interdisciplinary Physical Restraint Assessment" and in June 2017, the home had implemented a new minimizing of restraining program titled "Least Restraint Program".

To determine if the home had completed any appropriate initial assessments or quarterly reassessments of restraints implemented for residents since the compliance due date, the Inspector reviewed the home's current minimizing of restraining policies and completion of restraint assessments in PCC.

The Inspector's review of the home's current policy titled "Least Restraint Policy - LTC" operational date February 5, 2017, identified that "The policy of this Hospital is: The Least Restraint Program is to be followed".

The Inspector also reviewed the home's current program titled "Least Restraint Program" effective June 2017, that indicated "Current needs are determined through on-going assessment by the interdisciplinary team" and that registered staff "completes a thorough assessment within 24 hours of admission". The program did not specify the specific assessment(s) to be completed on admission, when restraints were implemented or quarterly, and did not refer to the restraint assessments in PCC.

On a date in August 2017, Inspector #625 reviewed resident #004's chart and located an "Initial Assessment for Use of Physical Restraint" dated on a date in the winter of 2017, and two "Quarterly Review for Use of Physical Restraint" dated the spring and summer of 2017, completed for the resident in PCC. Neither "Quarterly Review for Use of Physical Restraint" identified the type of restraints being reviewed and in use.

On a date in August 2017, Inspector #625 reviewed resident #005's chart and located an "Initial Assessment for Use of Physical Restraint" dated on a date in the fall of 2016, and two "Quarterly Review for Use of Physical Restraint" dated the winter and spring of 2017, in PCC. Neither "Quarterly Review for Use of Physical Restraint" identified that the resident used a specific restraint in use and the assessment completed in the spring of 2017 was blank and had not been completed.

During an interview with the Resident Assessment Instrument (RAI) Coordinator on a date in August of 2017, they confirmed that the "Quarterly Review for Use of Physical Restraint" dated on a date in the spring of 2017, for resident #005

was blank and had not been completed.

The home has failed to comply with CO #001 as the home did not, for any of the restraints that were in use by residents #004 and #005, or for any of the restraints in use in the home, ensure the restraints were reassessed and documented, by the interdisciplinary team, at least quarterly on the "Longterm Care Interdisciplinary Physical Restraint Assessment". In addition, the home did not complete a quarterly review of resident #005's restraint use using any restraint assessment form.

Previous non-compliance related to this legislation, Ontario Regulation 79/10, s. 8 (1) (b) was issued during the following inspections:
- a Written Notification/Compliance Order issued from inspection 2016_269627_0021 on November 10, 2016; and
- a Written Notification/Compliance Order issued from inspection 2015_320612_0015 on October 29, 2015.

The decision to issue this Compliance Order was based on the scope which demonstrated a pattern, the severity which indicated the potential for actual harm to occur, and the home's compliance history, which included the licensee's continued non-compliance with this area of the legislation. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 03, 2017

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. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall ensure that an interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, is developed and implemented in the home.

The licensee shall ensure that the skin and wound care program meets the requirements identified in Ontario Regulation 79/10, s. 50.

Grounds / Motifs :

1. The licensee has failed to ensure that a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions was developed and implemented in the home.

The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #004 was at risk for, or had, altered skin integrity.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Quality Improvement and Required Programs" completed by the home on August 23, 2017. The home had responded affirmatively, that the interdisciplinary skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, was developed and implemented in the home.

On August 24, 2017, during a review by Inspector #625 of "Nursing Meeting" minutes dated May 30, 2017, it was identified that the home did not have three required programs developed and implemented, including a skin and wound care program.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager clarified that the home did not have a skin and wound care program in place. (625)

2. On a date in August 2017, Inspector #196 observed altered skin integrity on resident #003's body.

During an interview with Inspector #196 on a date in August 2017, the LTC Manager of the home reported that a skin and wound care program had not been implemented in the home.

The decision to issue this Compliance Order was based on the severity which indicated the potential for actual harm to occur and, although the home did not have a history of non-compliance in this area, the scope was widespread representing a systemic failure that has the potential to affect a large number of residents in the home. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.
O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall ensure that an interdisciplinary continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable, is developed and implemented in the home.

The licensee shall ensure that the continence care and bowel management program meets the criteria identified in Ontario Regulation 79/10, s. 51.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable was developed and implemented in the home.

During a staff interview with Inspector #196, it was identified that resident #001 used a device related to elimination.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager stated that a continence care and bowel management program had not

yet been developed or implemented in the home. (196)

2. The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #004 used a device related to elimination.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager stated that a continence care and bowel management program had not yet been developed or implemented in the home. (625)

3. The most recent submitted Resident Assessment Instrument (RAI) – Minimum Data Set (MDS) identified that resident #005 used a device related to elimination.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Quality Improvement & Required Programs" completed by the home. The home has responded affirmatively, that the interdisciplinary continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable, was developed and implemented in the home.

Inspector #625 reviewed the "Nurse Meeting" minutes dated May 30, 2017, that identified that the home did not have a continence care and bowel management program in place but that it was a mandatory program.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager clarified that a continence care and bowel management program had not yet been developed and implemented in the home.

The decision to issue this Compliance Order was based on the severity which indicated the potential for actual harm to occur and, although the home did not have a history of non-compliance in this area, the scope was widespread representing a systemic failure that has the potential to affect a large number of residents in the home. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee shall ensure that an interdisciplinary pain management program to identify pain in residents and manage pain, is developed and implemented in the home.

The licensee shall ensure that the pain management program meets the criteria identified in Ontario Regulation 79/10, s. 52.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary pain management program to identify pain in residents and manage pain was developed and implemented in the home.

Inspector #625 reviewed the "LTCH Licensee Confirmation Checklist Quality Improvement and Required Programs" completed by the home on August 23, 2017. The home had responded affirmatively, that the interdisciplinary pain management program to identify pain in residents and manage pain, was developed and implemented in the home.

On a date in August 2017, during a review by Inspector #625 of "Nursing Meeting" minutes dated May 30, 2017, it was identified that the home did not have three required programs developed and implemented, including a pain management program.

During an interview with Inspector #625 on a date in August 2017, the LTC Manager clarified that a pain management program had not yet been developed and implemented in the home.

The decision to issue this Compliance Order was based on the severity which indicated the potential for actual harm to occur and, although the home did not have a history of non-compliance in this area, the scope was widespread representing a systemic failure that has the potential to affect a large number of residents in the home. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 07, 2018

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Katherine Barca

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