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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 6, 2017	2017_669642_0011	001812-17, 001817-17, 001818-17	Follow up

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road Box 179 Wawa ON P0S 1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 19-23, 2017

This Follow up inspection is related to three compliance orders (CO) issued from inspection #2016_283542_0005. CO #001, s. 19 (1) was related to neglect of multiple residents. CO #002, s. 6 (1), was related to a resident's plan of care providing clear direction. CO #003, O. Reg. 79/10, s. 15 (1) was related to residents not being assessed when bed rails were being used and bed systems evaluated in accordance with evidence-based practices to keep residents safe.

A Critical Incident (CI) System inspection was conducted concurrently with this inspection, for details, see inspection #2017_669642_0012.

During the course of the inspection, the inspector(s) spoke with Director of Patient Care (DOPC), Maintenance Staff, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Worker (PSW), residents, and family members.

During the course of the inspection, the inspector directly observed the delivery of resident care, staff to resident interactions, resident to resident interactions, conducted a daily tour of the resident home areas, reviewed resident health care records, reviewed policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #003	2016_283542_0005	642
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_283542_0005	642

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 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 the written plan of care for resident #007 set out clear directions to staff and others who provided direct care to the resident.

Inspector #642 conducted a Follow up inspection to CO #002 which was served to the Licensee, under inspection report #2016_283542_0005. The CO required the home to do the following by the end of December, 2016:
"The licensee shall ensure that resident #006's plan of care sets out clear directions to staff and others who provide direct care. Specifically the licensee shall ensure the following is completed for resident #006;
a) ensure that the plan of care provides clear direction with regards to the all restraints used for resident #006
b) ensure that restraint consents and physician's orders are current and specific for resident #006."

The Licensee was in compliance with this order however new additional non-compliance was identified during this inspection related to plan of care. During this Follow up inspection, Inspector #642 reviewed a document for resident #007 titled "Bed System Entrapment Risk Assessment (March 2016)," dated in February, 2017 and checked off under section F. (1.) it stated "No bed rails used." This document was reviewed with the Director of Patient Care (DOPC) on June 23, 2017 and they stated that the plan was for the resident to not have bed rails.

Inspector reviewed resident #007's most up to date written care plan dated in June, 2017, and under interventions for the risk of falls it stated, "Do not use 2 side rails. Resident uses two top bed rails only."

Inspector reviewed the resident's electronic copy of the Resident Assessment Protocols (RAPS) report dated in June, 2017. When resident #007 was in bed, staff were to use both upper rails only and resident relied on staff for assistance.

Inspector #642 observed the unit for four days in June, 2017 and resident #007 had only one upper bed rail on the window side in the up position during this inspection.

Inspector reviewed resident #007's daily paper flow chart titled "Seven Day Observation & Monitoring Form" dated in June, 2017. The RPNs or PSWs sign this form daily after providing resident care. Under section "P) Devices and Restraints: # of bedrails used", it

was documented that resident #007 had used two bed rails at night for five nights in June, 2017, and during the day for three days in June, 2017. Inspector #642 observed the unit for two days in June, 2017, and had observed one upper bed rail in use for resident #007 while they were in bed.

Inspector interviewed RPN #102 who stated that resident #007 uses upper bed rails and RPN #102 stated that the one bed rail was up on the window side but "technically they do not need it."

Inspector #642 interviewed the DOPC on June 30, 2017 on the telephone and they stated that for resident #007 the plan of care did not provide clear direction for all staff and others who provide care. [s. 6. (1) (c)]

Additional Required Actions:

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

Issued on this 18th day of September, 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) :	AMY GEAUVREAU (642)
Inspection No. / No de l'inspection :	2017_669642_0011
Log No. / No de registre :	001812-17, 001817-17, 001818-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 6, 2017
Licensee / Titulaire de permis :	LADY DUNN HEALTH CENTRE 17 Government Road, Box 179, Wawa, ON, P0S-1K0
LTC Home / Foyer de SLD :	LADY DUNN HEALTH CENTRE 17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kadean Ogilvie-Pinter

To LADY DUNN HEALTH CENTRE, 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_283542_0005, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The Licensee shall ensure that resident #007's plan of care sets out clear directions to staff and others who provide direct care.
Specifically the Licensee shall ensure the following is completed for resident #007:
a) ensure that the plan of care provides clear direction with regards to resident #007's bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure the written plan of care for resident #007 set out clear directions to staff and others who provided direct care to the resident.

Inspector #642 conducted a Follow up inspection to CO #002 which was served to the Licensee, under inspection report #2016_283542_0005. The CO required the home to do the following by the end of December, 2016:
"The licensee shall ensure that resident #006's plan of care sets out clear directions to staff and others who provide direct care. Specifically the licensee shall ensure the following is completed for resident #006;
a) ensure that the plan of care provides clear direction with regards to the all restraints used for resident #006
b) ensure that restraint consents and physician's orders are current and specific for resident #006."

The Licensee was in compliance with this order however new additional non-compliance was identified during this inspection related to the plan of care. During this Follow up inspection, Inspector #642 reviewed a document for resident #007 titled "Bed System Entrapment Risk Assessment (March 2016)," dated in February, 2017 and checked off under section F. (1.) it stated "No bed rails used." This document was reviewed with the Director of Patient Care (DOPC) on June 23, 2017 and they stated that the plan was for the resident to not have bed rails.

Inspector reviewed resident #007's most up to date written care plan dated in June, 2017, and under interventions for the risk of falls it stated, "Do not use 2 side rails. Resident uses two top bed rails only."

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Inspector #642 observed the unit for four days in June, 2017 and resident #007 had only one upper bed rail on the window side in the up position during this inspection.

Inspector reviewed resident #007's daily paper flow chart titled "Seven Day Observation & Monitoring Form" dated in June, 2017. The RPNs or PSWs sign this form daily after providing resident care. Under section "P) Devices and Restraints: # of bed rails used," it was documented that resident #007 had used two bed rails at night for five nights in June, 2017, and during the day for three days in June, 2017. Inspector #642 observed the unit for two days in June, 2017, and had observed one upper bed rail in use for resident #007 while they were in bed.

Inspector interviewed RPN #102 who stated that resident #007 uses upper bed rails and RPN #102 stated that the one bed rail was up on the window side but "technically they do not need it."

Inspector #642 interviewed the DOPC on June 30, 2017 on the telephone and they stated that for resident #007 the plan of care did not provide clear direction for all staff and others who provide care.

The decision to issue this compliance order was based on the scope which was identified as isolated, the severity which indicated the potential for harm, and the compliance history which despite previous non-compliance issued, non-compliance continued with this section of the legislation. During previous inspections: #2016_283542_0005 issued a Compliance Order (CO) and a Written Notification (WN) on Dec. 21, 2016; inspection #2015_332575-0020 a Voluntary Plans of Correction (VPN) and a WN were issued on Dec. 22, 2015; inspection 2015_376594_0015 a CO and a WN were issued on Oct 6, 2015. [s. 6 (1)(c)]
(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 15, 2017

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 6th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

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