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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2016	2016_282543_0001	034917-15	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

PINECREST
1220 VALLEY DRIVE KENORA ON P9N 2W7

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

TIFFANY BOUCHER (543), ALAIN PLANTE (620), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 4-13, 2016

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

In addition to this inspection the following logs were completed; 001817-15, 031483 -15 & 033370-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Staff (RNs and RPNs, Dietitian), RAI/MDS Coordinator, Personal Support Workers (PSW), Dietary Supervisor, Dietary Aides, Physiotherapy Staff, Recreation Staff, Housekeeping Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Skin and Wound Care
Snack Observation
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.

11 WN(s)
6 VPC(s)
4 CO(s)
0 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 LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff employed by the home had received training as required in section 76 (2) of the LTCHA 2007; prior performing their responsibilities.

On January 11, 2016 the ADOC provided Inspector #543 with a list (will be referred to as ADOC List) of staff members that included all training and/or orientation that was completed and a list of all staff employed in the home was provided by the Human Resources (HR)Department (will be referred to as HR List). The Inspectors reviewed

both lists and identified that the names did not match.

The ADOC list did not include nine staff members that were listed on the HR list. The ADOC list revealed that 14 staff members had worked at least one shift in the home, providing care to residents before education and/or orientation was completed. The HR list identified nine staff who had worked at least one shift in the home, providing care to residents before education and/or orientation was completed.

On January 12, 2016, a meeting with the ADOC and Inspectors #543 and #612 was held. The ADOC confirmed that the nine staff members from the ADOC list and the 14 staff members on the HR list did not receive training and/or orientation prior to providing care to residents in the home.

During an interview with RN #114, they identified that the home does not provide nearly enough training, nor is it often enough. They also stated that new hires do begin providing care to residents before orientation is completed.

During an interview with the DOC, they confirmed that newly hired employees provided care to residents before their orientation was completed. [s. 76. (2)]

2. The licensee has failed to ensure that the persons who have received training under subsection (2) receive re-training in the areas mentioned in that subsection at times or intervals provided for in the regulations.

Inspectors #543 and #612 reviewed the home's "Required Program Binder Checklist", which was the required annual re-training for registered staff in the home. Topics in this training binder included, Falls Prevention, Skin and Wound Care Program, Continence Care and Bowel Management Program, Pain Management Program and the Responsive Behaviour Program. The "Required Program Binder Checklist" did not include re-training related to the Prevention of Abuse and Neglect, Minimizing Restraints or Infection Prevention and Control.

A review of the staff list provided revealed that 119 staff members required re-training for the year 2015. During an interview with the Inspector, the Assistant Director of Care identified that re-training was offered to 36 registered nursing staff members, of those 22 completed the re-training. No other direct care staff members were provided any re-training required by the LTCHA 2007 and regulations.

During an interview with RPN #123 regarding education provided to staff they stated that the home did not provide ongoing training to current employees. [s. 76. (4)]

Additional Required Actions:

CO # - 001, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #001 was released from the physical device and repositioned at least once every two hours.

On January 9, 2016 at 0930 hrs, Inspector #543 observed resident #001 sitting in a chair with a fastened restraint. The Inspector noted that this resident was not repositioned nor was the restraint released for more than one hour.

On January 10, 2016 at 1430 hrs, Inspector #543 observed resident #001 up in their chair with a restraint applied. At 1515 hrs the Inspector observed that the resident was restless, and fidgeted in their chair. At 1530hrs the Inspector noted that no staff member had checked on the resident, repositioned the resident, or released the restraint for the last hour. Resident #001 remained in their chair with the restraint applied until the Inspector left the unit at 1600 hrs.

On January 10, 2016 at 0945hrs the Inspector observed resident #001 being brought

from the washroom to the TV room with a fastened restraint. The Inspector observed this resident from 0945hrs until the resident was transferred to the dining room at 1150hrs. The Inspector observed the resident throughout the lunch meal and at no time was this resident repositioned, nor was the restraint released. At 1305hrs right after the lunch meal a volunteer came and brought the resident off the unit, returning at 1430hrs. The volunteer placed the resident in the TV room and informed the Inspector that they do not toilet or reposition the resident when they take them off the unit. This resident was not repositioned and the restraint was not released until the PSWs came to get them at 1500hrs.

During an interview with PSW #107 they confirmed that they did not know what the expectation was, but that they reposition residents when they can. PSW #107 stated that they will reposition a resident when they require toileting or when they return them to bed for a nap.

During an interview with the DOC, they confirmed that residents with a restraint should be repositioned every one to two hours and that this should be documented hourly on the restraint sheet if they are released from the restraint. They further confirmed that this resident required the restraint, and that staff should have released the restraint every two hours and checked on the resident hourly.

During an interview with PSW #112, they stated that it is the home’s expectation that any resident who requires a restraint is repositioned and the restraint is released at a minimum every two hours. [s. 110. (2) 4.]

2. The licensee failed to ensure that resident #004 was released from the physical device and repositioned at least once every two hours.

Inspector observed resident #004 in their chair with a restraint applied on January 8, 2016 between 1115hrs and 1330hrs and on January 9, 2016 between 0945hrs and 1145hrs. Resident #004's restraint was not released and the resident was not repositioned during those periods of time.

An interview with PSW #112, PSW #116, RPN #117, RN #100 confirmed that staff are to complete a safety check every hour and release the restraint and reposition the resident every two hours.

A review of the home's Minimizing Restraints-PASD Use (NUR 400) noted that while a

resident is restrained they must be monitored at least every hour by a member of the registered nursing staff or by another staff member as authorized to do so. This policy revealed that a resident with a restraint must be released from the physical device and repositioned at least once every two hours. [s. 110. (2) 4.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Infection Prevention and Control program evaluation was kept that included the names of the persons who participated, a summary of the changes made, and the date any changes were implemented.

On January 12, 2016, Inspector #543 requested from the ADOC the written records of the annual evaluation of the home's Infection Prevention and Control (IPAC) program, who was not able to provide same. In a conversation the ADOC they confirmed that there was not any written documentation for evaluation of the home's IPAC.

An interview with the Administrator, confirmed that the home has not kept written records of program evaluations. [s. 229. (2) (e)]

2. The licensee has failed to ensure that staff participated in the implementation of the hand hygiene program.

On January 8, 2016, the Inspector observed a medication pass by RPN #106. This staff member was observed to pour medication for one resident, give the medication and assisted the resident to drink from a cup, move the medication cart to the sitting/TV room and document something in the medical record. The RPN then poured another medication, scratched their face then mixed the medication in a cup then administered it. They then went back to the medication cart, dispensed another medication, poured a supplement, opened and closed drawers on the medication cart and then administered the medication to a resident. At no time did the Inspector observe RPN #106 perform hand hygiene or wear gloves. There was no hand sanitizer on the medication cart.

On January 10, 2016, the Inspector observed RPN #115 administer a medication to a resident, pour another medication, lick their fingers while handling a capsule, and then dropped the capsule in the medication cup. Following this they tried to retrieve it with their finger, and then administered the medication to a resident. Throughout the entire medication pass the inspector did not observe RPN #115 perform hand hygiene. This RPN then went on to the dining room and assisted a resident to eat. They did not perform hand hygiene prior to performing this task.

During an interview with the DOC, they stated they were aware that hand hygiene is a problem in the home, in the dining room and with medication passes. They confirmed that the expectation is that hand hygiene is to be done before and after any contact with residents. Hand sanitizer is to be on the medication cart and hand hygiene is to be performed between medication administrations. [s. 229. (4)]

3. The licensee has failed to ensure that staff participated in the implementation of the hand hygiene program.

On January 8, 2016, the Inspector observed RPN #117 administer medication to a resident and touch their wheelchair. The staff member then proceeded to another resident and began to feed them. RPN #117 did not perform hand hygiene between residents. Following this they moved to another table to feed another resident without performing hand hygiene.

During an interview with RN #124, they revealed that the home's expectation was that hand hygiene is to be performed prior to and after contact with a resident. [s. 229. (4)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #009's care was provided to the resident as specified in the plan.

A review of resident #009's plan of care revealed that this resident required two persons and a mechanical lift for toileting.

On January 9, 2016, Inspector #543 observed PSW#108 and #109 assisted resident #009 to the toilet without the use of a mechanical lift.

On January 9, 2016, Inspector #543 observed PSW#108 and #109 transferred this resident to the washroom, with two persons without the use of a mechanical lift. [s. 6. (7)]

2. The licensee has failed to ensure that resident #004's plan of care was provided to the resident as specified in the plan.

On January 9, 2016, at 0945 hrs, Inspector #612 observed resident #004 sitting in their

chair. The Inspector observed the resident from 0945 hrs until 1145hrs, when resident #004 was brought back to the dining room for lunch and they were not toileted during that time frame.

A review of resident #004's health care records revealed that resident #004 was at risk for recurrent urinary tract infections. The plan of care stated that resident was to have some care provided and resident should be checked every 2 hours while awake.

Inspector interviewed PSW #116 who stated that resident #004 was to be toileted in the morning between breakfast and lunch. They confirmed that resident required assistance from two staff to toilet.

During an interview with RN #122 they confirmed that resident #004 should have been toileted prior to lunch as per the plan of care. [s. 6. (7)]

3. The licensee has failed to ensure resident #025's plan of care was provided to the resident as specified in the plan.

Inspector observed the breakfast service on January 11, 2016 and lunch on January 10, 2016 during lunch service. Inspector noted that resident #025 had not received their fluids in an assistive device.

Inspector observed resident #025 during the dinner service on January 10, 2016 and noted that resident received their fluids in an assistive device.

A review of resident #025's plan of care revealed that resident #025 required their fluids to be in an assistive device.

During an interview with the dietary aide #151 they stated that resident #025 was better able to consume their fluids with the use of an assistive device. [s. 6. (7)]

4. The licensee has failed to ensure that resident #009's plan of care was revised when the resident's care needs changed.

A review of resident #009's most recent plan of care revealed under the Activities of Daily Living focus that this resident required a mechanical lift for transferring and toileting. This plan of care under the Falls focus also revealed that this resident has an unsteady gait, and to ensure the environment is safe for ambulation. The Continence Care focus

section identified that the resident was a total assist to toilet.

During an interview with RPN #111 they confirmed that this resident was no longer ambulating.

During an interview with PSW #109 they stated that resident #009 required a mechanical lift for transferring. They stated this resident cannot transfer independently.

During an interview with RN #110 they stated that resident #009 required a mechanical lift for transferring and toileting and was no longer able to ambulate. RN #109 confirmed to the inspector that this resident's plan of care required updating specifically related to transferring, toileting and ambulating. [s. 6. (10) (b)]

5. The licensee has failed to ensure that resident #001's plan of care was revised when the resident's care needs changed.

A review of resident #001's plan of care revealed that this resident no longer ambulated and required extensive assistance with transferring. Another section of this resident's plan of care identified that this resident wanders, and should be assessed annually for this behaviour.

During an interview with PSW #113 they stated that this resident used to wander around the unit and in and out of other residents rooms, but that the behaviour no longer occured.

During an interview with PSW #112 they stated that this resident no longer ambulates independently, and required two people for assistance. [s. 6. (10) (b)]

6. The licensee has failed to ensure that resident #017 was reassessed and their plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector observed resident #017 on January 5, 2016 during lunch and supper and January 8 and 9, 2016 during lunch and noted that staff were feeding resident and resident did not have an item that they required.

A review of resident #017 health care records revealed the following intervention under the nutritional care focus:

-Resident #017 required a certain level of assistance and required a specific item for meals.

During an interview with the Inspector, the Registered Dietitian confirmed that they last assessed resident #017 in September, 2015 and resident was eating with a certain level of assistance from staff with the specified item. The RD assesses residents quarterly, unless a referral or concerns are brought forward in-between.

Interviews with RN #100, #114 and PSW #116 confirmed that the staff feed resident #017 for all meals and that the specified item was no longer used. They confirmed that the plan of care should be updated to reflect resident #017's current level of care. [s. 6. (10) (b)]

7. The licensee has failed to ensure that resident #018 was reassessed and their plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector observed resident #018 on January 5, 2016 during lunch and supper and January 8 and 9, 2016 during lunch. The inspector observed that this resident was served their meal at the same time as the other residents at their table. The inspector noted that resident #018 took a long time to eat their meal, and had not finished their meal by the time all other residents' had left the dining room. Staff moved resident #018 to another location to continue eating their meal with staff supervision.

A review of resident #018's health care records revealed that resident #018 required extra time and should receive their meal as soon as possible.

During an interview with the inspector, the Registered Dietitian confirmed that staff are no longer following this intervention and have not been doing it for quite some time. The RD confirmed that the plan of care should be reviewed and revised to reflect resident #018's current care requirements. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents #009, #004 and #025 care is provided as specified in the plan, and that resident #009, #001, #017 and #018's plan of care are reviewed and revised when the residents care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the Recreational and Social Activities program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Inspector requested a copy of the home`s Recreational and Social Activities program. Upon review of the program, the inspector noted that the last review date listed on the policies provided was April, 2005.

During an interview with the Administrator they confirmed that the Recreational and Social Activities program had not been reviewed and updated annually. [s. 30. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Recreational and Social Activities program was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the program included the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends.

On January 8, 9, 10 and 11, 2016, Inspectors #543 and #612 observed on units two and four that numerous residents were left in their wheelchairs, or wandering about the units. The inspectors did not observe any activities provided or offered to these residents.

During an interview with a member of the recreation team they stated that too often the department is short staffed and that activities are cancelled. Inspector #543 reported that they and Inspector #612 observed that residents were left sitting in their wheelchairs in the lounge areas on units two and four. This staff member confirmed that residents are often left sitting in the lounge areas because activation staff just cannot get to the residents to porter them to activities. They stated that many residents do not get enough stimulation throughout the day, mostly related to lack of staffing. This staff member stated that activity scheduling during evening and weekends was difficult as staffing is

limited. They further confirmed that for the month of December 2015, numerous activities were cancelled.

During an interview with Inspectors #543 and #612, the Administrator and the DOC, they confirmed that staffing in the Activation department has been a concern. They revealed that it was not until recently that the department had a full staff compliment.

A review of the home's Activation staff schedule revealed that for the month of December 2015, there were four days and two days in January 2016 where no staff members were scheduled in the activation department.

A review of the home's Activity Schedule for residents revealed that in November 2015, there were four days where no activities were scheduled on the weekend, and 22 days where no activities were in the evening.

A review of the home's Activity Schedule for residents revealed that in December 2015, there were 20 days where no activities were scheduled in the evening and four days with no activities scheduled.

A review of the home's Activity Schedule for residents revealed that in January 2016, there were 25 days where no activities were scheduled in the evening, 10 days with no activities scheduled on the weekend and one day with no activities scheduled. [s. 65. (2) (b)]

2. The licensee has failed to ensure that the program included the assistance and support to permit the residents to participate in activities that may be of interest to them if they were not able to do so independently.

During an interview with resident #023 they stated that they were not able to attend many activities due to not being able to get to the activities independently. Resident #023 reported that no staff come and assist them to attend activities that they are interested in.

On January 8, 9, 10 and 11, 2016, Inspectors #543 and #612 observed on units two and four that numerous residents were left in their wheelchairs for long periods of time with no activities provided to them.

During an interview with PSW #102 they stated that the residents on unit two stay in the

TV lounge unless a staff member from the activation department assists residents to an activity.

During an interview with the recreational aid (RA) #147, they stated that there are not enough staff in the activity department to ensure that residents are portered to various activities. They reported that the nursing staff are often busy and not able to assist with portering residents.

During an interview with the Administrator and the DOC they confirmed that it was the expectation that the activity department staff as well as nursing staff assist with portering residents to the activities they wish to participate in.

A review of the home's policy titled, Planning and Delivery of Recreation and Leisure Activities, policy number ACT 030, dated April 2005 stated that nursing staff shall assist staff with bringing residents to and from planned activities. [s. 65. (2) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's activation program included the development and implementation of a schedule of recreation and social activities that are offered during evenings and weekends; and that the program includes the assistance and support to permit the residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner.

During an interview with resident #011, #012, #013 and #014 they stated that they were not offered between-meal beverage in the morning.

On January 9, 2016, Inspector #612 observed on unit two that the staff did not bring fluids to all residents on the unit and only two residents received fluids as they requested it.

During an interview with PSW #107 they stated that on January 8, 2016 fluids were not provided to residents on unit 4 as no one in the dietary department brought them to the unit.

Inspector interviewed RN #122 who confirmed that residents were to be offered fluids in the morning between breakfast and lunch and that they were not aware that residents were not offered fluids on January 9, 2016.

During an interview with the Dietary Manager they confirmed that the dietary staff were supposed to bring the fluids to the unit and the nursing staff are to offer the residents something to drink. The Dietary Manager stated that on January 8, 2016 the dietary staff member was new, therefore was not familiar with the routine. The Dietary Manager was unable to provide any reasoning as to why fluids were not provided on the 9th of January. [s. 71. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were served course by course unless otherwise indicated by the resident or by the resident's assessed needs.

On January 9, 2016, Inspector #612 observed that during the lunch meal service on unit two that ten residents were served their lunch plate prior to completing their soup.

During an interview with the Dietary Manager they confirmed that residents are to be served course by course unless otherwise indicated in the plan of care. The Dietary Manager confirmed that there was no indication in the ten residents plan of care that they were to receive their meal all at once.

A review of the home's Pleasant Dining with Dignity policy(#DTY 135) revealed that meals shall be served one course at a time unless individual residents request otherwise. [s. 73. (1) 8.]

2. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

On January 8, 2016, Inspector #612 observed that during the lunch service on unit two, an RN was feeding resident #021 while standing up.

On January 9, 2016, Inspector #612 observed that during the lunch service on unit two, a PSW was feeding two different residents. The PSW was squatting and not sitting in a chair.

On January 8, 2016, Inspector #612 observed that during the lunch service on unit four, a PSW was feeding resident #007 and resident #025 while standing up.

During an interview with the Registered Dietitian and RN #124 they confirmed that the home's expectation was that staff are seated while feeding residents therefore they are able to feed the residents at the appropriate level. [s. 73. (1) 10.]

3. The licensee has failed to ensure that no person simultaneously assisted more than two residents who needed total assistance with eating or drinking.

On January 8, 2016, Inspector #612 observed that during the lunch service on unit two, the RN fed four residents at a table, resident #008, #019, #020 and #021.

Inspector interviewed the Dietary Manager and Registered Dietitian who confirmed that the expectation was that no staff feed more than two residents at once. [s. 73. (2) (a)]

4. The licensee has failed to ensure that a resident who required assistance with eating or drinking was not served their meal until someone was available to provide the assistance required by the resident.

On January 5, 2016, the Inspector observed the dining service on unit two during lunch. Inspector noted that the residents at a table were served their meal at 1215hrs. At 1235hrs PSW #150 sat down with resident #004 and resident #017 and fed them their meal. At 1250hrs a PSW sat down with resident #018 and #022 and fed them their meal.

On January 8, 2016, the Inspector observed the dining service on unit two and noted that resident #023 at a table had their food sitting in front of them for ten minutes prior to staff assisting them with finishing their meal.

During an interview with PSW #150 they stated that residents who require assistance with their meal typically wait greater than five minutes for assistance with their meal due to staff not being available to assist them.

During an interview with the Dietary Manager they stated that the Dietary Staff are not to serve residents who require assistance with eating until a staff member is able to assist them.

Inspector reviewed policy number DTY 135- Pleasant Dining with Dignity which indicated that the delivery of a meal to residents requiring assistance with eating shall occur no more than five minutes in advance of assistance being provided. According to the Ontario Regulations 79/10, section 72 (2) (b), no resident will be served a meal until someone is available to provide the assistance required by the resident. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the following:

1)residents are served course by course unless otherwise indicated by the resident or by the resident's assessed needs;

2)that proper techniques are used to assist residents with eating, including safe positioning of residents who required assistance;

3)that no person simultaneously assists more than two residents who need total assistance with eating or drinking; and

4)that a resident who requires assistance with eating or drinking is not served their meal until someone was available to provide the assistance required by the resident, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record of the annual Minimizing of Restrainting- PASD Use Program evaluation was kept that included the names of the persons who participated, a summary of the changes made, and the date any changes were implemented.

On January 12, 2016, Inspector #543 requested from the ADOC the written records of the annual evaluation of the home's Minimizing of Restraint- PASD Use program, who was not able to provide same. In a conversation the ADOC they confirmed that there was not any written documentation for evaluation of the Minimizing of Restraint- PASD Use program.

During an interview with the Administrator, they confirmed that the home has not kept written records of program evaluations.

A review of the home's Minimizing Restraint-PASD Use identified the following under the annual program evaluation:
-there will be an annual analysis of restraining of residents by use of a physical device by the Home's Restraint Use Committee.
-once every calendar year an evaluation will be made to determine the effectiveness of the policy and identify any changes and improvements necessary to minimize restraints and ensure that any restraining that is done is necessary in accordance with the Act and Regulations. [s. 113. (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record of the annual Minimizing of Restrainting- PASD Use Program evaluation was kept that included the names of the persons who participated, a summary of the changes made, and the date any changes were implemented, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment of care of resident #015 that resulted in harm or a risk of harm had occurred was immediately reported to the Director.

A review of a critical incident (CI) revealed that an incident of alleged staff to resident abuse had occurred. According to the CI the incident was not repeated immediately, but a day later.

During an interview with the DOC they stated that this CI was submitted late. They confirmed that they submitted the incident to the Director after the home's internal investigation was completed. [s. 24. (1)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a weight monitoring system to measure and record with respect to each resident's body mass index and height was completed annually.

In stage one of the inspection, Inspectors #543 and #612 identified through the census review that residents heights were not being completed on an annual basis.

A review of medical health records revealed that residents #004, #005 and #022 did not have their heights measured for the year 2015.

During an interview with the Registered Dietitian and the RAI coordinator they confirmed the above mentioned three residents did not have their heights measured for the year 2015. They stated that it was the home's expectation that all residents have their heights measured and documented. [s. 68. (2) (e) (ii)]

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

Issued on this 9th day of February, 2016

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TIFFANY BOUCHER (543), ALAIN PLANTE (620), SARAH CHARETTE (612)
Inspection No. / No de l'inspection :	2016_282543_0001
Log No. / Registre no:	034917-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 5, 2016
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	PINECREST 1220 VALLEY DRIVE, KENORA, ON, P9N-2W7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	KEVIN QUEEN

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that any staff members currently employed by the licensee who had not received training prior to commencing their responsibilities, and on an ongoing basis any new employees hired by the licensee, receive training as required in section 76 (2) of the LTCHA 2007; prior performing their responsibilities.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff employed by the home had received training as required in section 76 (2) of the LTCHA 2007; prior performing their responsibilities.

On January 11, 2016 the ADOC provided Inspector #543 with a list (will be referred to as ADOC List) of staff members that included all training and/or orientation that was completed and a list of all staff employed in the home was

provided by the Human Resources (HR)Department (will be referred to as HR List). The Inspectors reviewed both lists and identified that the names did not match.

The ADOC list did not include nine staff members that were listed on the HR list. The ADOC list revealed that 14 staff members had worked at least one shift in the home, providing care to residents before education and/or orientation was completed. The HR list identified nine staff who had worked at least one shift in the home, providing care to residents before education and/or orientation was completed.

On January 12, 2016, a meeting with the ADOC and Inspectors #543 and #612 was held. The ADOC confirmed that the nine staff members from the ADOC list and the 14 staff members on the HR list did not receive training and/or orientation prior to providing care to residents in the home.

During an interview with RN #114, they identified that the home does not provide nearly enough training, nor is it often enough. They also stated that new hires do begin providing care to residents before orientation is completed.

During an interview with the DOC, they confirmed that newly hired employees provided care to residents before their orientation was completed.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health, safety and well-being of all residents. Previous related non-compliance was issued in a similar area and the scope was determined to be widespread, as this has the potential to affect all residents in the home.

(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

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. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure that residents #001 and #004 who are restrained by a physical device are released from the physical device and repositioned at least once every two hours.

Grounds / Motifs :

1. The licensee failed to ensure that resident #004 was released from the physical device and repositioned at least once every two hours.

Inspector observed resident #004 in their chair with a restraint applied on January 8, 2016 between 1115hrs and 1330hrs and on January 9, 2016

between 0945hrs and 1145hrs. Resident #004's restraint was not released and the resident was not repositioned during those periods of time.

An interview with PSW #112, PSW #116, RPN #117, RN #100 confirmed that staff are to complete a safety check every hour and release the restraint and reposition the resident every two hours.

A review of the home's Minimizing Restraints-PASD Use (NUR 400) noted that while a resident is restrained they must be monitored at least every hour by a member of the registered nursing staff or by another staff member as authorized to do so. This policy revealed that a resident with a restraint must be released from the physical device and repositioned at least once every two hours.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health, safety and well-being of all residents. Previous related non-compliance was issued in this area and the scope was determined to be a pattern, as this has the potential to affect more than the fewest numbers of residents or staff. (612)

2. The licensee failed to ensure that resident #001 was released from the physical device and repositioned at least once every two hours.

On January 9, 2016 at 0930 hrs, Inspector #543 observed resident #001 sitting in a chair with a fastened restraint. The Inspector noted that this resident was not repositioned nor was the restraint released for more than one hour.

On January 10, 2016 at 1430 hrs, Inspector #543 observed resident #001 up in their chair with a restraint applied. At 1515 hrs the Inspector observed that the resident was restless, and fidgeted in their chair. At 1530hrs the Inspector noted that no staff member had checked on the resident, repositioned the resident, or released the restraint for the last hour. Resident #001 remained in their chair with the restraint applied until the Inspector left the unit at 1600 hrs.

On January 10, 2016 at 0945hrs the Inspector observed resident #001 being brought from the washroom to another location with a fastened restraint. The Inspector observed this resident from 0945hrs until the resident was transferred to the dining room at 1150hrs. The Inspector observed the resident throughout the lunch meal and at no time was this resident repositioned, nor was the restraint released. At 1305hrs right after the lunch meal a volunteer came and

brought the resident off the unit, returning at 1430hrs. The volunteer placed the resident in the TV room and informed the Inspector that they do not toilet or reposition the resident when they take them off the unit. This resident was not repositioned and the restraint was not released until the PSWs came to get them at 1500hrs.

During an interview with PSW #107 they confirmed that they did not know what the expectation was, but that they reposition residents when they can. PSW #107 stated that they will reposition a resident when they require toileting or when they return them to bed for a nap.

During an interview with the DOC, they confirmed that residents with a restraint should be repositioned every one to two hours and that this should be documented hourly on the restraint sheet if they are released from the restraint. They further confirmed that this resident required the restraint, and that staff should have released the restraint every two hours and checked on the resident hourly.

During an interview with PSW #112, they stated that it is the home's expectation that any resident who requires a restraint is repositioned and the restraint is released at a minimum every two hours.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health, safety and well-being of all residents. Previous related non-compliance was issued in this area and the scope was determined to be a pattern, as this has the potential to affect more than the fewest number of residents or staff.

(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

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

Order / Ordre :

The licensee shall ensure that all staff participate in the implementation hand hygiene program.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participated in the hand hygiene program.

On January 8, 2016, the Inspector observed RPN #117 administer medication to a resident and touch their wheelchair. The staff member then proceeded to another resident and began to feed them. RPN #117 did not perform hand hygiene between residents. Following this they moved to another table to feed another resident without performing hand hygiene.

During an interview with RN #124, they revealed that the home's expectation was that hand hygiene is to be performed prior to and after contact with a resident.
(612)

2. The licensee has failed to ensure that staff participated in the hand hygiene program.

On January 8, 2016, the Inspector observed a medication pass by RPN #106. This staff member was observed to pour medication for one resident, give the medication and assisted the resident to drink from a cup, move the medication cart to the sitting/TV room and document something in the medical record. The RPN then poured another medication, scratched their face then mixed the medication in a cup then administered it. They then went back to the medication cart, dispensed another medication, poured a supplement, opened and closed

drawers on the medication cart and then administered the medication to a resident. At no time did the Inspector observe RPN #106 perform hand hygiene or wear gloves. There was no hand sanitizer on the medication cart.

On January 10, 2016, the Inspector observed RPN #115 administer a medication to a resident, pour another medication, lick their fingers while handling a capsule, and then dropped the capsule in the medication cup. Following this they tried to retrieve it with their finger, and then administered the medication to a resident. Throughout the entire medication pass the Inspector did not observe RPN #115 perform hand hygiene. This RPN then went on to the dining room and assisted a resident to eat. They did not perform hand hygiene prior to performing this task.

During an interview with the DOC, they stated they were aware that hand hygiene is a problem in the home, in the dining room and with medication passes. They confirmed that the expectation is that hand hygiene is to be done before and after any contact with residents. Hand sanitizer is to be on the medication cart and hand hygiene is to be performed between medication administrations.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health, safety and well-being of all residents. Previous related non-compliance was issued in this area and the scope was determined to be a pattern, as this has the potential to affect more than the fewest number of residents or staff. (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all staff who has received training under subsection (2) receive re-training in the following areas:

-The Residents' Bill of Rights
-The long-term care home's mission statement
-The long-term care home's policy to promote zero tolerance of abuse and neglect of residents
-The duty under section 24 to make mandatory reports
-The protections afforded by section 26
-The long-term care home's policy to minimize the restraining of residents
-Fire prevention and safety
-Emergency and evacuation procedures
-Infection prevention and control
-All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities
-Any other areas provided for in the regulations; and
That all staff will receive re-training annually thereafter.

Grounds / Motifs :

1. The licensee has failed to ensure that the persons who have received training under subsection (2) receive re-training in the areas mentioned in that subsection, at times or intervals provided for in the regulations.

Inspectors #543 and #612 reviewed the home's "Required Program Binder Checklist", which was the required annual re-training for registered staff in the home. Topics in this training binder included, Falls Prevention, Skin and Wound Care Program, Continence Care and Bowel Management Program, Pain Management Program and the Responsive Behaviour Program. The "Required Program Binder Checklist" did not include re-training related to the Prevention of Abuse and Neglect, Minimizing Restraints or Infection Prevention and Control.

A review of the staff list provided revealed that 119 staff members required re-training for the year 2015. During an interview with the Inspector, the Assistant Director of Care identified that re-training was offered to 36 registered nursing staff members, of those 22 completed the re-training. No other direct care staff members were provided any re-training required by the LTCHA 2007 and regulations.

During an interview with RPN #123 regarding education provided to staff they stated that the home did not provide ongoing training to current employees.

The decision to issue this compliance order was based on the severity, which was determined to be minimal harm or potential for actual harm to the health, safety and well-being of all residents. Previous related non-compliance was issued in a similar area and the scope was determined to be widespread, as this has the potential to affect all residents in the home.
(543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 11, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
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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 5th day of February, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

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