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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 27, 2016	2016_269627_0011	011605-16	Resident Quality Inspection

Licensee/Titulaire de permis

THE CITY OF GREATER SUDBURY
200 Brady Street PO Box 5000 Stn A SUDBURY ON P3A 5P3

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

PIONEER MANOR
960 NOTRE DAME AVENUE SUDBURY ON P3A 2T4

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

SYLVIE BYRNES (627), MARIE LAFRAMBOISE (628), SARAH CHARETTE (612), TIFFANY BOUCHER (543)

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): May 2-6, and May 9-13, 2016.

Additional logs inspected during the RQI included:

Three critical incidents submitted by the home related to resident falls;
Two critical incidents submitted by the home related to unexpected deaths;
Four critical incidents submitted by the home related to alleged staff to resident abuse;
One critical incident submitted by the home related to visitor to staff abuse;
One critical incident submitted by the home related to resident to resident abuse;
One critical incident submitted by the home related to resident elopement;
One complaint related to improper care of a resident;
One complaint related to lack of care conferences;
And a follow up intake related to the use of bedrails.

During the course of the inspection, the inspector(s) spoke with the Administrator, Manager of Resident Care (MRC), Program Coordinators (PCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Sudbury City Counsellor, Coordinator of Recreational Therapy and Volunteers, Laundry, Housekeeping and Material Supervisor, Manager of Therapeutic Services, Manager of Physical Services, Manager of Administration, Scheduling Coordinator, Housekeepers, Maintenance staff, Documentation RPN, residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **5 VPC(s)**
- **2 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 O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff and others who provided direct care to the residents had completed the education of the revised Restraint Use (Least Restraint) policy, as ordered in Inspection 2015_391603_0029, Compliance Order (CO) #007.

CO #007 was issued on January 7, 2016, with a compliance date of February 5, 2016, to address failure to comply with O. Reg 79/10, s. 15 (1). On February 3, 2016, the licensee requested an extension to the compliance order which was granted. The amended compliance date was April 15, 2016.

The compliance order required the licensee to ensure that when bed rails were used:
a) The resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.
b) Steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
c) Other safety issues related to the use of bed rails were addressed, including height and latch reliability.
d) A record was kept to indicate for each resident where bed rails were used, when the resident was assessed and his or her bed system was evaluated.
e) The licensee was to review and revise the policy Restraint Use (Least Restraint), to include requirements under a, b, c, and d.
f) The licensee was to educate all staff and others who provide direct care to residents related to the revised policy and shall implement the new policy.

The licensee was compliant with section a, b, c, d and e, however education related to the revised policy was not provided to all staff and others who provided direct care to residents.

During an interview with Inspector #627, the Manager of Resident Care (MRC) stated that changes had been made to the policies titled "Restraint Use (Least Restraint)", last reviewed on February 5, 2016, and to the "Beds and Mattresses: Selection and Safety", last revised on February 5, 2016, which addressed the risk of entrapment for residents using bed rails. They also stated that the education provided to the registered staff for the "Entrapment Risk Project", as referred to by the home, included a review of the changes to the policies titled "Restraint Use (Least Restraints)" and "Beds and Mattresses: Selection and Safety", which had been completed during the monthly staff meetings in February, March and April, 2016. The MRC reported that if a staff member was unable to attend, they were to read the changes in the minutes of the meetings which were provided to all registered staff by email. As well, they were to send an email which acknowledged that they had read and understood the changes made to the policies.

During the same interview, the MRC stated that the education for the PSWs was completed by a particular RPN when the RPN had completed the Bed System Entrapment Risk Assessment for each resident with bed rails on every unit. The MRC stated that the particular RPN had completed education with the PSWs as they were available and that the particular RPN had flexed their working hours to ensure that they were in the home at times with the evening staff. The MRC further stated that the PSWs only needed to know how to raise and lower the bed rails and which bed rails were required, and that the education on the policies was not relevant.

A review of the minutes with the email acknowledgement sheet revealed that one RN and one RPN had not responded to the emails and that their emails were not marked as read. As well, another RPN's emails were marked as deleted and emptied. There was no indication that the emails had been read. A review of the sign in sheets of the staff members who attended the meetings failed to reveal a signature for a specific RN and the two specific RPNs.

On May 12, 2016, during an interview with the Inspector, an identified RPN confirmed that they had not attended any staff meetings in February, March and April, 2016, and that they had not read the emails for the "Entrapment Risk Project" which highlighted the changes to the policies titled "Restraint Use (Least Restraint)" and "Beds and Mattresses:

Selection and Safety".

During an interview with the Inspector, the MRC confirmed that one RN and two RPNs had not completed the education of the revised policies. As well, the MRC could not confirm that all PSWs had received training from RPN #122, as no records had been kept. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

During the course of the inspection, Inspector #612 received multiple complaints throughout the home from residents and their family members related to hot water not being available for showers and tub baths.

Inspector #627 took the water temperature on a specific date and at a specific time:
- Sink in an identified resident's room in a specific home area was 58.6 degrees Celsius
- Sink in an identified resident's room in a specific home area was 59.3 degrees Celsius
- Shower in shower room on Park Place was 54.1 degrees Celsius
- Sink in an identified resident's room in a specific home area was 51.2 degrees Celsius

Inspector #612 took the water temperatures on a specific date, at a specific time, on the following units:
- Sink in tub room on York was 56.4 degrees Celsius
- Sink in tub room on Ramsey was 58.3 degrees Celsius
- Sink in an identified resident's room in a specific home area was 58 degrees Celsius

Inspector #612 reviewed the "Domestic Water Temperature Control Sheet", where the maintenance staff members recorded the water temperatures on the weekends and noted the following:
-March 27, 2016, a water temperature which was taken in the basement was recorded to be 56.3 degrees Celsius.
-May 9, 2016, a water temperature which was taken in a resident's room in a specific home area was recorded to be 59.7 degrees Celsius.
-May 10, 2016, a water temperature which was taken a resident's room in another home area was recorded to be 55.7 Celsius.
-June 6, 2016, a water temperature which was taken in Park Place (no room number identified) was recorded to be 59.3 degrees Celsius.
-June 7, 2016, a water temperature which was taken in Park Place (no room number identified) was recorded to be 53.9 degrees Celsius.

The Inspector reviewed the home's policy titled, "Physical Services Policies and Procedures: Water Temperature", last revised February 6, 2014, which stated that the temperature of the water serving all bathtubs, showers and hand basins used by residents shall not exceed 49 degrees Celsius and shall be controlled by a device, inaccessible to residents, that regulated the temperature. Hot water temperature was monitored daily by the Building Automated Computer System. Immediate action was to be taken where water temperatures exceeded 49 degrees Celsius.

The Inspector interviewed a maintenance staff member who stated that they recorded water temperatures on the weekend on the "Domestic Temperature Control", and then signed off that they had completed the work order form. They further stated, upon reviewing the weekend documented temperatures with the Inspector, that when they identified a temperature as being over 49 degrees Celsius, they took no further action.

The Inspector interviewed the Manager of Physical Services. They stated that there was no alert in place when the hot water in the tub rooms, showers or the sinks in resident's rooms exceeded 49 degrees Celsius. They confirmed that the water temperature was not checked in areas where residents accessed hot water during the week as the temperature readings were taken in the boiler room. They stated that the system was set for 80 degrees Celsius as the system took into account outside temperatures and they had to account for the water traveling through a large building, therefore there was anticipated heat loss. They further stated that the water temperature in the residents' rooms were only checked on weekends, one area was randomly chosen, and documented on the "Domestic Temperature Control" sheet. They confirmed that the water temperature was not checked in areas where the residents access hot water during the week. The further confirmed that no action was taken when the water temperatures exceeded 49 degrees Celsius, only when below 49 degrees Celsius. [s. 90. (2) (h)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

During the course of the inspection, Inspector #612 received multiple complaints throughout the home from residents and their family members related to hot water not being available for showers and tub baths.

Inspector #543 interviewed an RPN who stated that at times in the evening, usually for the last few baths given, the home ran short of hot water. They stated that the PSWs had filled basins with hot water from the medication room and provided bed baths to the residents, rather than a tub bath or a shower.

Inspector #543 interviewed a PSW who confirmed that the home ran out of hot water almost on a daily basis in the mornings. They stated that they heated water in the kitchen on the unit and provided sponge baths to the residents.

Inspector #627 interviewed a PSW who confirmed that they often ran out of hot water for bathing residents and offered the residents an afternoon tub bath or bed bath instead of a bath before noon.

Inspector #612 interviewed an RN who confirmed they were often short of hot water throughout the building. They reported that the staff adjusted the residents' bath routines and offered a tub baths or a bed bath in the afternoon.

During Stage 1 of the Inspection, Inspector #612 overheard the staff on a specific home area stating that they had no hot water and they had to stop giving baths. The Inspector reviewed a daily report sheet from another specific home area which stated that there was no hot water until 1100 hours on the day shift.

On May 12, 2016, the Inspector met with the Manager of Physical Services who confirmed that the domestic hot water temperature on May 2, 2016, at 1100 hours was 37.4 degrees Celsius and that by 1200 hours it was 45.9 degrees Celsius.

The Inspector interviewed the Administrator, the Manager of Resident Care and the Manager of Physical Services. They all confirmed that there were dips in the domestic hot water temperature, where it went below 40 degrees Celsius. The Manager of Physical Services explained that the system was controlled by a computer which was checked frequently throughout the day. When the water temperature went below 40 degrees Celsius, they had manually overridden the system to increase water temperature. The Administrator and the Manager of Physical Services stated that they had received a couple of proposals to update the current hot water system as they had recognized that there had been times when hot water was not available, typically when multiple baths/showers were being performed on the units in the morning. [s. 90. (2) (i)]

3. The licensee has failed to ensure that procedures were developed and implemented to ensure that, if the home was using a computerized system to monitor the water temperature, the system was checked daily to ensure that it was in good working order.

During the course of the inspection, Inspector #612 received multiple complaints throughout the home from residents and their family members related to hot water not being available for showers and tub baths.

The Inspector reviewed the "Domestic Water Temperature Control tracking form" and noted that there were no temperatures recorded for the weekend dates of May 7, and 8,

2016, as there was no thermometer. The weekend dates for April 9, 10, 23, 24, March 12, and 13, 2016 were left blank.

A review by the Inspector of the policy titled "Physical Services Policies and Procedures: Title: Water Temperature, last revised February 6, 2014 and noted the following: "Temperature monitoring:
Pioneer Manor has a computerized system to monitor the water temperatures (Building Automation System/BAS). The system is monitored Monday to Friday by the Physical Services Manager or designate alternate. On weekends and statutory holidays the maintenance staff on day shift report water temperatures from randomly selected areas throughout the building and temperatures are recorded on an audit form. Unusual increases in water temperature from sources accessible to residents must be reported immediately. All baths and showers must be cancelled immediately until the issue is investigated and corrected. The Physical Services Manager or the RN Supervisor notifies each home area of the problem. The Registered Staff in each area must ensure that all staff are made aware of the problem and that it is communicated from shift to shift. Depending on the situation, signage may be used to alert residents, staff and visitor not to use hot water."

The Inspector interviewed a maintenance staff member who confirmed that during the weekends, they checked the water temperature manually and wrote it down on the "Domestic Water Temperature Control tracking form." They further stated that they had access to the system but had not checked the system to ensure it was functioning during the weekends. They called the Manager of Physical Services on the weekends if the temperatures were irregular. The Manager of Physical Services checked the system daily (during the week) and ensured it was in working order.

Inspector #612 interviewed the Manager of Physical Services who stated that they monitored the computerized system between Monday and Friday every week. They confirmed that the system was not checked on the weekend, unless they were alerted by the maintenance staff that there was a concern with the water temperature. [s. 90. (2) (j)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

A complaint was received by the Director related to the staff in the home taking an extended period of time to answer an identified resident's call bell.

On a specific date, Inspector #612 observed an identified resident return to their room and press their call bell at a certain time. The Inspector remained across from the

resident's room in the hallway. The Inspector observed that three PSWs were visible in front of the nurses' station down the hall, where they prepared their carts for their shift. One of the PSW then walked down the hallway, past the identified resident's room to answer another call bell. They returned to the nurses' station, going past the identified resident's room without answering their call bell. All three PSWs then entered the report room with the RPN and closed the door at a specific time. The resident's family member had approached the RPN for assistance for the identified resident, 15 minutes after the resident had rung their call bed. The RPN stated to the family member that the staff members were in report now and that the resident had to wait. At a specific time, the staff ended report and Inspector #612 asked a PSW why this specific resident's call bell had not been answered; they replied "I don't know". The resident's call bell was then answered, 22 minutes after they had rung their call bell.

The Inspector interviewed the identified resident who confirmed that the staff often took a long time to answer their call bell, specifically during report time, which resulted in them waiting a long time before receiving the care they required.

The Inspector reviewed the identified resident's plan of care under a specific focus which stated that the resident was to receive a certain type of care on demand. Under a separate focus, it was stated that the resident required the assistance of two staff members for another type of care.

The Inspector interviewed a PSW who confirmed that the identified resident was able to ring for assistance and that staff were to respond as soon as possible.

The Inspector interviewed an RN who confirmed that the expectation was that staff answered call bells as soon as possible, even during their report. The RN confirmed that a staff member should have answered the identified resident's call bell, especially since they had walked past the room twice while the bell was ringing.

In an interview, the MRC confirmed that the home's expectation was that call bells be answered as soon as possible and that a staff member answered call bells even during report. [s. 3. (1) 4.]

2. The licensee has failed to ensure that every residents have his or her personal health information kept confidential.

On a specific date, at a specific time, during a medication pass, Inspector #627 observed

that the computer monitor on the medication cart was left open in the upright position and displayed a resident's electronic medication administration record (oneMAR), which contained personal health information (PHI). The medication cart was at the entrance of the dining room, close to the elevator.

On a specific date, at a specific time, Inspector #627 observed an RPN in the dining room administering medication to a resident. The computer monitor on the medication cart was left open in the upright position which displayed a resident's PHI. The medication cart was at the entrance of the dining room, close to the elevator.

On a specific date, at a specific time, Inspector #627 observed an RPN in a resident's room administering medication. The computer monitor on the medication cart was left open in the upright position and displayed the resident's oneMAR, which contained personal health information (PHI). The medication cart was in the hallway.

On a specific date, at a specific time, Inspector #627 observed an RPN administering medications to three residents. The Inspector observed that the RPN discarded the empty pill pouches in a trash bag on the side of the medication cart. On one of the pill pouches, the Inspector was able to identify the name of a resident and a medication name that the resident was receiving.

On a specific date, for a time period one hour and five minutes, Inspector #627 observed an RPN administering medication in the dining room of a home area. The Inspector observed that the RPN walked away from the cart with residents' (PHI) displayed on the monitor screen, during each medication pass, for each resident. At a specific time, the Inspector observed residents leaving the dining room and walking in front of the medication cart where the PHI of a resident was displayed. As well, the Inspector observed that the RPN discarded the empty pill pouches in a trash bag on the side of the medication cart. Inspector #627 removed two empty pouches from the trash bag and was able to read the names of two residents and the medications that they had received.

A review of the "Resident Care Policies and Procedures: Medication Administration" revealed the following: ... "In addition, privacy is maintained at all times for all resident information (e.g., oneMAR)." As well, the policy identified the following: "All medication packaging is to be destroyed in a manner that maintains confidentiality - strike through resident's name with a Sharpie marker, cut off name/room number from label/pouch or placing the pouch in a bowl of water".

During an interview with the Inspector, an RPN confirmed that the home's expectation was that all personal health information be kept private and that the electronic medication administration record (oneMar) displayed on the monitor screen should be turned off or folded over as to not display the resident's personal health information and that this was not done.

During an interview, an RPN stated that they attempted to destroy the resident's name by ripping the pouch where the resident's name was written but this was difficult. They further stated that the medication pouches were discarded in the regular trash.

During an interview, an RPN confirmed that the home's expectation was that the name be removed by cutting through the resident's name before discarding the empty pill pouch. They further confirmed that the medication administration record screen displayed on the computer monitor, on the medication cart, should have been folded over or shut down and this was not done.

During an interview with the Inspector, the MRC confirmed that the home's expectation was that all residents' PHI be protected. The medication nurse was to strike through resident's name with a Sharpie marker, or cut off the name and room number from the pouch, or by placing the pouch in a bowl of water to make the name illegible. They further confirmed that the medication administration record (oneMar) displayed on the computer monitor, on the medication cart, should be closed or folded over as to not display the resident's personal health information when the medication nurse stepped away from the cart. [s. 3. (1) 11. iv.]

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 every resident is properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs, specifically by ensuring that an identified resident's call bell is answered in a timely manner. As well, ensure that all residents' personal health information is kept confidential, to be implemented voluntarily.

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 the care set out in the plan of care was provided to the resident as specified in the plan.

A resident was identified through Resident Assessment Instrument-Minimum Data Set (RAI-MDS) as having worsening impaired skin integrity during stage one of the inspection.

The Inspector reviewed the resident's most recent plan of care, related to the focus of impaired skin integrity. The plan of care instructed the staff to not leave the resident with a certain type of equipment after care had been provided.

On a specific date, the Inspector observed the identified resident in the dining room for the morning and lunch meals with the equipment still in place.

On a specific date, Inspector #543 observed the identified resident with the equipment still in place.

The Inspector spoke with an RN who confirmed that the identified resident was not to have this equipment in place while engaged a certain activity.

On a specific date, the MRC confirmed that all of the resident who had this type of

equipment, should not have had it in place while engaged in certain activity, unless specified in their plan of care. [s. 6. (7)]

2. On three specific dates, Inspector #612 observed an identified resident with a certain type of equipment in place.

The Inspector reviewed an identified resident's plan of care under a specific focus and noted that the equipment was not to be left in place after the care was provided.

The Inspector interviewed a PSW who stated that the equipment was left in place for comfort measures as it may have been uncomfortable for the resident to apply and remove the equipment.

The Inspector reviewed the plan of care with an RN who confirmed that the plan of care indicated the equipment was to be removed after the care had been provided. The RN confirmed that the care was not provided to the resident as specified in the plan of care.

The Inspector interviewed the MRC who confirmed that the specific equipment should be removed from all residents after care had been provided, unless the plan of care specified not to. [s. 6. (7)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to an identified resident as specified in the plan.

During stage one of the RQI an identified resident reported that they had received a certain type of care in a specific way rather than their preferred way. They reported that staff told them this was a result of the unit being short staffed and not having had enough time.

Inspector #612 reviewed the resident task report on POC and noted that on a specific date, the resident had received care that was not in their preferred way.

The Inspector reviewed the resident plan of care which stated that the identified resident was to receive a certain type of care in their preferred way.

The Inspector interviewed a PSW and an RPN who stated that the intervention for this specified resident related to their preferred way of receiving a certain type of care had been in place for numerous months. The RPN confirmed that the care set out in the plan

of care was not provided to the identified resident as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident`s care needs changed or care set out in the plan was no longer necessary.

A resident was identified through RAI-MDS as having worsening impaired skin integrity during stage one of the inspection.

The Inspector reviewed the identified resident's plan of care related to impaired skin integrity which indicated that the resident had worsening skin integrity.

The Inspector reviewed an assessment form for the identified resident which indicated that the resident's skin integrity had worsened.

The Inspector spoke with an RN who confirmed that the identified resident's skin integrity had worsened. They also confirmed that the identified resident's plan of care was not reviewed or revised when the resident's care needs had changed to reflect the deterioration in the resident's impaired skin integrity. [s. 6. (10) (b)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident`s care needs changed or care set out in the plan was no longer necessary.

On a specific date, at a specific time, an RPN was observed providing a specific intervention and administering a specific medical treatment to a resident.

A review of the identified resident’s care plan in effect failed to reveal any focus, goals or interventions in regards to the specific medical treatment.

A review of the medical orders revealed that the resident was to receive the specific medical treatment.

During an interview with the Inspector, an RPN confirmed that the identified resident’s care plan had no focus, interventions or goals in regards to this medical treatment and should have. They further stated that the PSWs did not have access to the medication treatment records or the Doctor’s orders and the resident needed to be monitored for symptoms.

On a specific date, during an interview with Inspector #627, the Documentation RPN stated that the home's expectation was that a resident's care plan be updated when they received this specific medical treatment to ensure the resident's safety. The RPN confirmed that the identified resident's care plan should have been revised when the medical treatment was ordered and this had not been done. [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 the care set out in the plan of care is provided to three identified residents as specified in the plan. Furthermore, the licensee shall ensure that the plan of care for two other identified residents are reviewed and revised at least every six months and at any other time when the resident's 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. 27. Care conference

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a record was kept of the date, the participants, and the results of the care conferences.

Inspector #543 reviewed a complaint submitted to the Director by a family member of an identified resident. The complaint identified concerns related to the resident's annual care conference.

During an interview with Inspector #543, the Program Coordinator (PC) #117 stated that a "Health Case Conference Record" form was to be filled out by the RPN for every resident's care conference. This form contained areas to identify the reason for the conference, various aspects of the resident's health, the date, the care conference participants, the resident's representative and the results of the care conference.

The Inspector spoke with a Ward Clerk who confirmed that the RPN on the unit was responsible to fill the "Health Case Conference Record" which identified what concerns were addressed at the care conference and the outcome of the care conference.

Inspector #543 conducted a review of six residents' health care records (Health Case Conference Record). The review identified that four out of six, or 66 per cent, of the "Health Case Conference Records" had not included either: the date, the participants or the results of the care conference.

The Inspector reviewed the six resident records with an RPN who confirmed that the Health Case Conference Record was to be completed for every resident care conference. [s. 27. (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 a record is kept of the date, the participants and the results of the conferences, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a process to report and locate residents' lost clothing and personal items.

During the Resident Quality Inspection (RQI), concerns were brought forward during the resident interviews which related to missing clothing and missing personal belongings.

An identified resident reported to Inspector #627 that they had three missing items of clothing which they reported to the staff, a while ago. As well, they stated that a personal object of theirs had gone missing. The resident stated that they had reported this to the home.

Inspector #628 reviewed a progress note which revealed that the resident had reported to the staff that they were missing those items.

A second identified resident reported to Inspector #627 that a certain article of clothing was missing. They further stated that this had been reported to the staff that this certain article of clothing had gone missing.

A third identified resident reported to Inspector #627 that they had a certain article of clothing that went missing, which they had reported to a staff member.

A fourth identified resident reported to Inspector #543, that they had personal items that were missing. They further stated that this was reported to the staff, and that the item was still missing.

During an interview with the Inspector, an RPN stated that there was no process or forms to document or track a resident's missing belongings.

On a specific date, during an interview with Inspector #628, the Laundry, Housekeeping and Material Supervisor confirmed that the home did not have a process or procedure to monitor lost clothing or lost personal articles. They further stated that the home documented complaints, but that missing clothing and missing personal articles were considered concerns and not complaints.

On May 10, 2016, during an interview with Inspector #628, Program Coordinator #124 confirmed that the home had no process which documented a resident's lost clothing or personal belongings. [s. 89. (1) (a) (iv)]

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 process is in place to report resident's lost clothing and personal items, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program, specifically with hand hygiene being performed.

On a specific date, for a period of one hour and five minutes, Inspector #627 observed an RPN administering medications. The RPN was observed administering medication for 30 residents without performing hand hygiene in between residents. The Inspector observed the RPN perform hand hygiene four times throughout the entire medication pass.

The Inspector reviewed the home's policy titled "IC: Infection Prevention and Control Program: Hand Hygiene," last revised March 14, 2014. This policy indicated that hand hygiene would be performed before initial patient contact, before an aseptic procedure, after body fluid exposure risk and after patient or patient environment contact.

Inspector #627 interviewed the RPN, who confirmed that the home's expectation was that hand hygiene be performed between every resident during medication administration and that they had not done that.

On a specific date, Inspector #543 spoke with an RPN who confirmed that hand hygiene was to be performed after every contact with a resident and in between each resident when administering medications.

On a specific date, the Inspector spoke with PC #118, who confirmed that the staff were expected to perform hand hygiene before and after resident contact, and if administering medications, they were to perform hand hygiene between each resident. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the "IC: Infection Prevention and Control Program: Hand Hygiene Policy," is complied with. Specifically, that hand hygiene be performed before initial patient contact, before an aseptic procedure, after body fluid exposure risk and after patient or patient environment contact, to be implemented voluntarily.

WN #8: 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 any plan, policy, protocol, procedure or system was complied with.

Inspector #627 reviewed a Critical Incident report submitted to the Director alleging a responsive behaviour incident for an identified resident.

Inspector #627 reviewed the policy titled "Responsive Behaviors", last revised May 19, 2015, which indicated that the registered nursing staff members must document all episodes of this type of responsive behaviour, as an incident report in Point Click Care (PCC), selecting the proper "Type/Nature of Incident" from the drop down box.

A review of the identified resident's assessments in PCC failed to reveal an incident report for the resident's incident.

During an interview, an RPN stated that when this type of incident occurred, an incident report was to be completed in PCC.

During an interview with Inspector #627, the MRC confirmed that it was the expectation of the home that an incident report be completed in PCC for each incident of this type.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident (CI) report was submitted to the Director related to alleged staff to resident abuse. According to the CI, the program coordinator overheard a PSW speaking

loudly in an area of the home. An RPN reported that the PSW was yelling, angry, and made inappropriate comments to a resident. The CI identified that the resident requested to be removed from the PSW's care.

Inspector #543 spoke with the identified resident regarding the incident that had occurred, related to alleged staff to resident abuse. They confirmed that the PSW made inappropriate comments and had not listened to their concerns.

The Inspector reviewed the home's internal investigation notes, which identified that in an interview with an RPN, they stated that a PSW was observed to use profanity and talk negatively about the identified resident in the presence of the resident.

The Inspector spoke with the RPN, who stated that they had assisted the PSW with the identified resident's care. They confirmed that during that time they witnessed the PSW make inappropriate comments in the presence of the resident. The RPN stated that they could tell by the look on the identified resident's face that this was troubling to the resident. The RPN stated that the resident later told them that this PSW was always mean to them.

The Inspector spoke with the PSW, who stated that they had only said that they were injured in front of the identified resident.

The Inspector reviewed the home's policy titled "Abuse: Resident Abuse/Neglect." This policy indicated that residents will be free from abuse by staff, volunteers, service providers, visitors and other residents. Each resident has the right to complain and be assured of a full, equitable investigation in the event of resident abuse or neglect. Their policy defined verbal abuse, as any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth. This policy indicated that was the responsibility of employees to respond to residents with patience and compassion.

There was an outstanding CO for this legislation at the time of the inspection served on April 16, 2016, Inspection No: 2016_320612_0010, with a compliance date of September 6, 2016. [s. 20. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided a staffing mix that was consistent with residents' assessed care and safety needs.

During the course of the inspection, the Inspectors received multiple complaints from residents and family members related to insufficient staffing within the home.

Inspector #628 interviewed an identified resident from the resident council, who indicated that the only outstanding issue that had not been resolved was the issue of insufficient staffing. They stated that on some units, when the home was short staffed, there was only one staff member caring for a large number of residents and when that happened, resident care was affected. For example, there were no tub baths or showers given to the residents.

Inspector #628 interviewed the liaison for Resident's Council who was the Coordinator of Recreational Therapy and Volunteers, on a specific date, who confirmed that the staffing

issue was addressed at the meeting held April 8, 2016, and that a response was received on April 15, 2016, from the Administrator. The response included that the home was utilizing external staffing resources however; they had to train the staff before they performed resident care. The home was reviewing their contingency plan to look at other disciplines assisting to allow nursing staff to focus on nursing duties. The Administrator also stated in the response that "although residents were not receiving their bath of choice, they were still bathed. The residents' routines may be altered when a unit was short staffed such as a resident being put to bed early."

Inspector #612 reviewed the Family Council meeting minutes from January to April, 2016. During the meeting held on January 12, 2016, the Family Council reported a concern regarding staff shortages over the Christmas break.

The Administrator attended the Family Council meeting held February 9, 2016, along with the MRC and a Sudbury City Counsellor who was a member of the Management Committee. The meeting minutes confirmed that "insufficient staffing was a long standing problem which affected all long term care homes. Sick calls and no shows happened daily and were worse on weekends". The Sudbury City Counsellor on the Management Committee was quoted as saying in the minutes, "we see the problem and continue to try to solve it."

During the Family Council meeting held March 8, 2016, the Council discussed that insufficient staffing remained an outstanding issue, however it was somewhat better.

During stage one of the RQI, two residents reported that they had received care in a specific way, rather than their preferred way. They reported that staff told them this was a result of the unit being short staffed and not having had enough time.

The Inspector reviewed the task report in Point of Care (POC) for one of the identified residents. On a specific date, the resident received care in a specific way that was not their preferred way. The Inspector reviewed a staffing sheet provided by the Manager of Administration and on that specific date, the unit was short a PSW for four hours.

The Inspector reviewed the task report in POC for another identified resident and noted that on a specific date, the resident care in a specific way, rather than in their preferred way. The Inspector reviewed a staffing sheet provided by the Manager of Administration and on that specific date, the unit was short a PSW for four hours.

The Inspector reviewed the identified resident's plan of care which stated that the resident was not to receive care in a specific way. The Inspector interviewed a PSW and an RPN #103 who stated that the intervention related to the care provided in the identified resident's way had been in place for numerous months.

Inspector #612 interviewed a member of the Family Council on May 11, 2016, and they confirmed that insufficient staffing remained an ongoing issue, which was discussed at every meeting.

The Inspector interviewed the Manager of Resident Care and the Administrator on a specific date. They stated that they were aware of the staffing concerns in the home and that they had done extensive work to try to manage the shortages within the home. [s. 31. (3)]

2. Inspector #612 and #543 received complaints related to call bells not being answered during shift report from four identified residents as well as the family members of three other identified residents.

Inspector #612 observed the shift report on a specific date, on a specific unit. The Inspector noted that a resident rang their call bell at a specific time and that it was not answered by staff until 22 minutes later. During the time that the call bell was ringing, the resident's family member approached an RPN and requested assistance for the resident. The RPN stated that the shift staff were in report and could not respond to the call bell at that time. The staff members remained in the report room with the door closed until a specific time.

Inspector #612 observed the shift report on a specific date, on a specific unit. The Inspector observed that an identified resident's call bell was ringing for 12 minutes and 45 seconds, prior to the call bell being answered. The staff members remained in the report room with the door closed until a specific time.

The Inspector interviewed the Manager of Resident Care on a specific date. They stated that the expectation of the home was that call bells were answered by a staff member during shift report, as soon as possible.

There was an outstanding compliance order for this legislation at the time of the inspection served on April 16, 2016, Inspection No: 2016_320612_0010, with a compliance date of June 14, 2016. [s. 31. (3)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to a report to the Director: that a final report was submitted to the Director within a period of time specified by the Director.

An alleged resident to resident incident of abuse had occurred. According the Critical Incident report, a resident assaulted another resident. At a later date, a request was made for the licensee to amend the critical incident to include long term actions to prevent recurrence.

On a specific date, the Inspector spoke with PC #118, who confirmed that they had only amended the report a few days ago, more than a year after the incident. [s. 104. (3)]

Issued on this 13th day of October, 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

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) :	SYLVIE BYRNES (627), MARIE LAFRAMBOISE (628), SARAH CHARETTE (612), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2016_269627_0011
Log No. / Registre no:	011605-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 27, 2016
Licensee / Titulaire de permis :	THE CITY OF GREATER SUDBURY 200 Brady Street, PO Box 5000 Stn A, SUDBURY, ON, P3A-5P3
LTC Home / Foyer de SLD :	PIONEER MANOR 960 NOTRE DAME AVENUE, SUDBURY, ON, P3A-2T4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Loubert

To THE CITY OF GREATER SUDBURY, 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)

Linked to Existing Order / Lien vers ordre existant: 2015_391603_0029, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall educate all staff and others who provide direct care to residents related to the revised policies titled "Beds and Mattresses: Selection and Safety", last revised February 5, 2016, and "Restraint Use (Least Restraint)", last revised February 5, 2016, which address the risk of bed rail entrapment. Specifically, the education of the revised policies shall be provided to two specified RPNs, one specified RN, PSWs and others who have not been provided with the education of the revised policies.

Grounds / Motifs :

1. The licensee has failed to ensure that all staff and others who provided direct care to the residents had completed the education of the revised Restraint Use (Least Restraint) policy, as ordered in Inspection 2015_391603_0029, Compliance Order (CO) #007.

CO #007 was issued on January 7, 2016, with a compliance date of February 5, 2016, to address failure to comply with O. Reg 79/10, s. 15 (1). On February 3, 2016, the licensee requested an extension to the compliance order which was granted. The amended compliance date was April 15, 2016.

The compliance order required the licensee to ensure that when bed rails were used:
a) The resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.
b) Steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.
c) Other safety issues related to the use of bed rails were addressed, including height and latch reliability.
d) A record was kept to indicate for each resident where bed rails were used, when the resident was assessed and his or her bed system was evaluated.
e) The licensee was to review and revise the policy Restraint Use (Least Restraint), to include requirements under a, b, c, and d.
f) The licensee was to educate all staff and others who provide direct care to residents related to the revised policy and shall implement the new policy.

The licensee was compliant with section a, b, c, d and e, however education related to the revised policy was not provided to all staff and others who provided direct care to residents.

During an interview with Inspector #627, the Manager of Resident Care (MRC) stated that changes had been made to the policies titled “Restraint Use (Least Restraint)”, last reviewed on February 5, 2016, and to the “Beds and Mattresses: Selection and Safety”, last revised on February 5, 2016, which addressed the risk of entrapment for residents using bed rails. They also stated that the education provided to the registered staff for the "Entrapment Risk Project", as referred to by the home, included a review of the changes to the policies titled “Restraint Use (Least Restraints)” and “Beds and Mattresses: Selection and Safety”, which had been completed during the monthly staff meetings in February, March and April, 2016. The MRC reported that if a staff member was unable to attend, they were to read the changes in the minutes of the meetings which were provided to all registered staff by email. As well, they were to send an email which acknowledged that they had read and understood the changes made to the policies.

During the same interview, the MRC stated that the education for the PSWs was completed by a particular RPN when the RPN had completed the Bed System Entrapment Risk Assessment for each resident with bed rails on every unit. The MRC stated that the particular RPN had completed education with the PSWs as

they were available and that the particular RPN had flexed their working hours to ensure that they were in the home at times with the evening staff.

A review of the minutes with the email acknowledgement sheet revealed that one RN and one RPN had not responded to the emails and that their emails were not marked as read. As well, one RPN's emails were marked as deleted and emptied. There was no indication that the emails had been read. A review of the sign in sheets of the staff members who attended the meetings failed to reveal a signature for a specific RN and the two specific RPNs.

On May 12, 2016, during an interview with the Inspector, an identified RPN confirmed that they had not attended any staff meetings in February, March and April, 2016, and that they had not read the emails for the "Entrapment Risk Project" which highlighted the changes to the policies titled “Restraint Use (Least Restraint)” and “Beds and Mattresses: Selection and Safety”.

During an interview with the Inspector, the MRC confirmed that one RN and two RPNs had not completed the education of the revised policies. As well, the MRC could not confirm that all PSWs had received training from the particular RPN, as no records had been kept.
(627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 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. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall ensure that procedures are developed and implemented to ensure that:

a) The temperature of the hot water in the home serving showers, tubs and hand basins, which are accessible to residents, is maintained at a temperature of at least 40 degrees Celsius and not exceeding a temperature of 49 degrees Celsius. An daily record of temperatures taken shall be maintained.
b) Immediate action shall to be taken to reduce the water temperature if the water temperature exceeds 49 degrees Celsius. A record of the actions taken which includes the date, time and the person(s) taking the actions shall be maintained.
c) The computerized system to monitor the water temperature shall be monitored daily to ensure that it is in good working order. A record of this monitoring shall be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

During the course of the inspection, Inspector #612 received multiple complaints throughout the home from residents and their family members related to hot water not being available for showers and tub baths.

Inspector #627 took the water temperature on a specific date, at a specific time:
- Sink in an identified resident's room in a specific home area was 58.6 degrees Celsius
- Sink in an identified resident's room in another specific home area was 59.3 degrees Celsius
- Shower in shower room on Park Place was 54.1 degrees Celsius
- Sink in an identified resident's room in another specific home area was 51.2 degrees Celsius

Inspector #612 took the water temperatures on a specific date, at a specific time, on the following units:
- Sink in tub room on York was 56.4 degrees Celsius
- Sink in tub room on Ramsey was 58.3 degrees Celsius
- Sink in an identified resident's room in a specific home area was 58 degrees Celsius

Inspector #612 reviewed the "Domestic Water Temperature Control Sheet", where the maintenance staff members recorded the water temperatures on the weekends and noted the following:
-March 27, 2016, a water temperature which was taken in the basement was recorded to be 56.3 degrees Celsius.
-May 9, 2016, a water temperature which was taken in a resident's room in a specific home area was recorded to be 59.7 degrees Celsius.
-May 10, 2016, a water temperature which was taken in a resident's room in another home area was recorded to be 55.7 Celsius.
-June 6, 2016, a water temperature which was taken in Park Place (no room number identified) was recorded to be 59.3 degrees Celsius.
-June 7, 2016, a water temperature which was taken in Park Place (no room number identified) was recorded to be 53.9 degrees Celsius.

The Inspector reviewed the home's policy titled, "Physical Services Policies and Procedures: Water Temperature", last revised February 6, 2014, which stated that the temperature of the water serving all bathtubs, showers and hand basins used by residents shall not exceed 49 degrees Celsius and shall be controlled by a device, inaccessible to residents, that regulated the temperature. Hot water temperature was monitored daily by the Building Automated Computer System. Immediate action was to be taken where water temperatures exceeded 49 degrees Celsius.

The Inspector interviewed a maintenance staff member who stated that they recorded water temperatures on the weekend on the "Domestic Temperature Control", and then signed off that they had completed the work order form. They further stated, upon reviewing the weekend documented temperatures with the Inspector, that when they identified a temperature as being over 49 degrees Celsius, they took no further action.

The Inspector interviewed the Manager of Physical Services. They stated that there was no alert in place when the hot water in the tub rooms, showers or the sinks in resident's rooms exceeded 49 degrees Celsius. They confirmed that the water temperature was not checked in areas where residents accessed hot water during the week as the temperature readings were taken in the boiler room. They stated that the the system was set for 80 degrees Celsius as the system took into account outside temperatures and they had to account for the water traveling through a large building, therefore there was anticipated heat loss. They further stated that the water temperature in the residents' rooms were

only checked on weekends, one area was randomly chosen, and documented on the "Domestic Temperature Control" sheet. They confirmed that the water temperature was not checked in areas where the residents access hot water during the week. The further confirmed that no action was taken when the water temperatures exceeded 49 degrees Celsius, only when below 49 degrees Celsius. (612)

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

During the course of the inspection, Inspector #612 received multiple complaints throughout the home from residents and their family members related to hot water not being available for showers and tub baths.

Inspector #543 interviewed an RPN who stated that at times in the evening, usually for the last few baths given, the home ran short of hot water. They stated that the PSWs had filled basins with hot water from the medication room and provided bed baths to the residents, rather than a tub bath or a shower.

Inspector #543 interviewed a PSW who confirmed that the home ran out of hot water almost on a daily basis in the mornings. They stated that they heated water in the kitchen on the unit and provided sponge baths to the residents.

Inspector #627 interviewed a PSW who confirmed that they often ran out of hot water for bathing residents and offered the residents an afternoon tub bath or bed bath instead of a bath before noon.

Inspector #612 interviewed an RN who confirmed they were often short of hot water throughout the building. They reported that the staff adjusted the residents' bath routines and offered a tub baths or a bed bath in the afternoon.

On May 2, 2016, at an approximate time, during Stage 1 of the Inspection, Inspector #612 overheard the staff on a specific unit stating that they had no hot water and they had to stop giving baths. The Inspector reviewed a daily report sheet from a different unit which stated that there was no hot water until 1100 hours on the day shift.

On May 12, 2016, the Inspector met with the Manager of Physical Services who confirmed that the domestic hot water temperature on May 2, 2016, at 1100 hours was 37.4 degrees Celsius and that by 1200 hours it was 45.9 degrees Celsius.

The Inspector interviewed the Administrator, the Manager of Resident Care and the Manager of Physical Services. They all confirmed that there were dips in the domestic hot water temperature, where it went below 40 degrees Celsius. The Manager of Physical Services explained that the system was controlled by a computer which was checked frequently throughout the day. When the water temperature went below 40 degrees Celsius, they had manually overridden the system to increase water temperature. The Administrator and the Manager of Physical Services stated that they had received a couple of proposals to update the current hot water system as they had recognized that there had been times when hot water was not available, typically when multiple baths/showers were being performed on the units in the morning. (612)

3. The licensee has failed to ensure that procedures were developed and implemented to ensure that, if the home was using a computerized system to monitor the water temperature, the system was checked daily to ensure that it was in good working order.

During the course of the inspection, Inspector #612 received multiple complaints throughout the home from residents and their family members related to hot water not being available for showers and tub baths.

The Inspector reviewed the "Domestic Water Temperature Control tracking form" and noted that there were no temperatures recorded for the weekend dates of May 7, and 8, 2016, as there was no thermometer. April 9, 10, 23, 24, March 12, and 13, 2016 were left blank.

The Inspector interviewed a maintenance staff member who confirmed that during the weekends, they checked the water temperature manually and wrote it down on the "Domestic Water Temperature Control tracking form." They further stated that they had access to the computer but had not checked the computer to ensure it was functioning during the weekends. They called the Manager of Physical Services on the weekends if the temperatures were irregular. The Manager of Physical Services checked the system daily (during the week) and ensured it was in working order.

Inspector #612 interviewed the Manager of Physical Services who stated that they monitored the computerized system between Monday and Friday every week. They confirmed that the system was not checked on the weekend, unless they were alerted by the maintenance staff that there was a concern with the water temperature. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Byrnes

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