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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 08, 2019	2018_703625_0023 (A1)	001569-18	Follow up

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

Princess Court
Princess Street Box 725 DRYDEN ON P8N 2Z4

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

Amended by TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home has requested and been granted an extension to the compliance due date for order #001.

Issued on this 8 th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 15 to 19, 2018.

The following intake was completed in this Follow-up inspection report:

- One log related to compliance order (CO) #001 from inspection #2017_435621_0026 pursuant to the Long-Term Care Homes Act (LTCHA), 2007, S.O. 2007, c. 8, s. 6 (7) related to providing care set out in the plan of care to the resident as specified in the plan.

Critical Incident System report #2018_703625_0024 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Resident Assessment Instrument (RAI) Coordinator, the Administrative Clerk, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

The Inspector also conducted observations of the care and services provided to residents, resident to resident interactions and staff to resident interactions. The Inspector reviewed residents' health care records (care plans, assessments, progress notes), a bed alarm log, relevant licensee policies and PSW worksheets.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration

During the course of the original inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **1 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

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

Compliance order (CO) #001 from inspection #2017_435621_0026 was served on January 17, 2018, with a compliance date of March 30, 2018. The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #014. During inspection of this order, Inspector #625 identified related non-compliance pursuant to the Long-Term Care Homes Act (LTCHA), 2007, c. 8, s. 6 (1) (c) involving resident #014.

Inspector #625 reviewed resident #014's care plan titled Risk of Injury from Falls, last updated in the summer of 2018, that identified the resident required the use of certain assistive devices, positioned in a specific manner when in bed.

The Inspector also reviewed PSW worksheets updated on October 11 and 17, 2018, which also identified the use of the assistive devices, positioned in a specific manner when in bed.

Inspector #625 observed resident #014's assistive devices on two consecutive dates in the fall of 2018, to be in a particular position, while the resident was not in bed.

During an interview with PSW #106, they attended resident #014's room with the Inspector and noted the assistive devices were positioned in a particular position. They stated that one of the devices was usually positioned in a particular position and referred to the PSW worksheet that identified the position of one of the devices. The PSW stated they were not sure of the location of the assistive device which was to be in a particular position, but believed it was the device closest to the resident's door.

During an interview with PSW #110, they stated that resident #014 used assistive devices in certain locations in specific positions and stated that the device to be positioned in a particular position was the one closest to the resident's window [not the one closest to the door]. During a second interview with the PSW, they stated that they thought they "got it wrong", that they now thought the device to be positioned in a particular position was the one closest to the door. The PSW then asked if the care plan listed specific wording which would identify which how each device was positioned.

During an interview with PSW #111, they referred to the PSW worksheet and identified that resident #014's assistive devices were to be positioned in specific positions. The PSW stated one of the devices positioned in a specific manner would be the one facing the door. During a subsequent interview, the PSW stated that the device was the one near the window.

During interviews with RPN #112, they stated the resident used assistive devices in particular positions, but they hadn't put the resident to bed lately and would have to look at the care plan. The RPN stated the care plan was "very confusing" as to which device was to be in which position, the one standing there looking at it or the one if you're laying in bed. The RPN indicated that they believed the device closest to the door would be the one positioned in a particular manner.

During an interview with the DOC, they stated that, during the inspection, a PSW had approached them and asked them which side of the bed was which. The DOC stated that maintenance and nursing staff had questioned the use of terms used to identify the location before and the DOC had explained it many times. The

DOC stated the differentiation would need to be made clear to the staff in the plans of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

CO #001 from inspection #2017_435621_0026 was served pursuant to the LTCHA, 2007, s. 6 (7) on January 17, 2018, with a compliance date of March 30, 2018. The order specifically identified that the licensee was to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #001. The findings supporting the order identified that the home had been non-compliant regarding the provision of care related to continence care and bowel management.

Inspector #625 reviewed the home's policy titled "Continence Care and Bowel Management Program", revised June 2014, which indicated that registered nursing staff were to obtain informed consent for treatment when establishing the initial care plan and when making changes to the care plan from the resident or substitute decision-maker (SDM). The policy also identified that registered nursing staff were to communicate to the resident or SDM whenever there was a significant change to the care plan regarding continence care and bowel management, on an ongoing basis.

During a review of PSW worksheets dated October 12, 17 and 18, 2018, Inspector #625 noted that residents #001, #005 and #008 had changes made to the times they were to be provided with continence related interventions by the staff. The Inspector noted that resident #005 had multiple times they were to be provided with a continence related intervention eliminated from their plan of care; resident #001 also had multiple times they were to be provided with continence related interventions eliminated, resulting in increased periods of time between the interventions; and resident #008 had multiple times they were to be provided with continence related interventions eliminated, resulting in increased periods of time between interventions, and the use of a particular night time continence related product, during the day.

During an interview with resident #001's family member/substitute decision-maker #115, they stated that they visited the resident regularly, had not been aware that

the home had made changes to the resident's continence related schedule, and believed that the increased length of time in between continence interventions was a long time for the resident not to be provided with the continence related intervention.

During an interview with the ADOC, they stated that the continence related schedules for multiple residents had been changed by the home. They identified that the home had not talked to any residents or families about the changes. The ADOC identified that the home had eliminated providing an intervention at a particular time to resident #005 as their spouse provided the intervention when they visited, but that the home had not communicated with the spouse about the elimination of the provision of the intervention by the home, and the spouse's role in providing that intervention to the resident on a daily basis.

During an interview with the DOC, they stated that the home had not obtained input from family members prior to making the changes to the continence related intervention times for residents. [s. 6. (5)]

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

The licensee has failed to comply with CO #001 from inspection #2017_435621_0026 issued on January 17, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #001.

Inspector #625 reviewed resident #001's plan of care, with a focus on falls prevention interventions, including:
- a care plan titled Risk of Injury from Falls, last updated in the summer of 2018, which identified the resident was to have two specific interventions in place, including the use of a personal assistance services devices (PASD); and
- a PSW worksheet, updated October 18, 2018, which identified the resident required a PASD when using their mobility device, and required a second falls prevention intervention.

On a date in the fall of 2018, the Inspector observed resident #001 using their

mobility device in the TV lounge without the PASD engaged.

During multiple observations on dates in the fall of 2018, the Inspector noted that the resident did not have the second falls prevention intervention in use.

During an interview with resident #001's family member #116 they stated that [during their regular visits with the resident], the resident did not have the second falls prevention intervention in use, which was also not in use at the time of the interview.

During an interview with PSW #117 in the fall of 2018, they attended the resident with the Inspector and confirmed that their PASD was not engaged. The PSW stated that they believed staff had not applied the resident's PASD when they had asssisted the resident to use their mobility aid.

During an interview with PSW #105 on a date in the fall of 2018, they attended the resident with the Inspector and acknowledged that the PASD for use with their mobility device was not engaged. The PSW also acknowledged that the resident did not have a second falls prevention intervention in place, as was required.

On a date in the fall of 2018, PSW #108 confirmed that resident #001 did not have a second falls prevention intervention in place.

During an interview with the DOC, they identified that the resident should have falls prevention interventions listed in their plan of care, including the use of the second falls prevention intervention, provided as indicated in their plan of care. [s. 6. (7)]

4. The licensee has failed to comply with CO #001 from inspection #2017_435621_0026 issued on January 17, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #015.

Inspector #625 reviewed the most recent Quarterly Nutrition Review – Nutrition Assessment, dated in the fall of 2018, which identified that staff were to continue with the current care plan and referred to the nutritional care plan.

The Inspector also reviewed resident #015's care plan titled Nutritional Care, last updated in the fall of 2018, which identified the resident required a particular diet, served in a particular manner, and required staff assistance with eating.

On a date in the fall of 2018, the Inspector observed resident #015 served an item during a meal service that was not consistent with the criteria listed in the resident's care plan.

On a date in the fall of 2018, during an interview with PSW #118 regarding the items they were assisting resident #015 to eat, they acknowledged that the food item did not meet the criteria listed in the care plan. They stated that they were aware that the resident was not supposed to be given food with a certain characteristic, but they were not sure how the actual characteristic of the food item was supposed to be.

On a date in the fall of 2018, during an interview with PSW #119 regarding the food item they had begun to assist the resident with during the meal, the PSW acknowledged that the item they were assisting resident #015 with was of a characteristic opposite to the item characteristic they were to provide to the resident. They stated that they were not sure of the parameters of the characteristic and just served the resident from what the kitchen provided. The PSW stated they were not aware that the resident's care plan identified their food was to be served in a particular manner.

On a date in the fall of 2018, during an interview with Dietary Aide #120 regarding the meal service they had provided to resident #015, they identified that the resident was supposed to have a particular diet with foods served in a particular manner, but that the food item had not been served in that manner due to steps involved in the preparation of the item.

During an interview with PSW #121 on a date in the fall of 2018, during the another meal, the PSW stated that the resident was given a diet of a characteristic that was not consistent with the diet listed in their care plan. [s. 6. (7)]

5. The licensee has failed to comply with compliance order #001 from inspection #2017_435621_0026 issued on January 17, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to:
"a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001, #006, #014 and #015;
b) Develop and implement a system to ensure that all direct care staff (PSWs, RPNs, RNs) who are involved in the care of residents, are engaged in the review and revision process of resident's plans of care, and are kept aware of every resident's most up to date plans of care as changes occur;
c) Implement an auditing process for resident's plans of care to ensure that all direct care staff are providing care as per the plan; and
d) Provide retraining to all direct care staff involved in the care of resident's in the home, of the home's policies and procedures related to resident's plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, and risks associated with not providing care as per the plan. The home is to maintain a record of the required retraining, who completed the retraining, when the retraining was completed, and what the retraining entailed."

The licensee completed step (b).

The licensee failed to complete steps (a), (c) and (d).

(A) With respect to step (a), the licensee was required to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of residents #001, #006, #014 and #015.

The licensee failed to ensure that staff provided care set out in the plan of care to resident #001 with respect to falls prevention, and resident #015, with respect to nutrition and hydration. Refer to WN #1, findings 3 and 4 for details.

(B) With respect to step (c), the licensee failed to implement an auditing process for residents' plans of care to ensure that all direct care staff provided care as per the plan.

During an interview with Inspector #625, the ADOC stated that they could not recall auditing the provision of resident care as identified in their plans of care, or that any audit records had been maintained. During a subsequent interview with the ADOC, they acknowledged that step (c) of the order had not been completed by the home.

During an interview with the DOC, they stated that they did not recall conducting any audits or maintaining any records of audits. During a subsequent interview with the DOC, they stated that step (c) of the order had not been completed as the home had not audited of the provision of resident care.

(C) With respect to step (d), the licensee failed to provide retraining to all direct care staff involved in the care of residents in the home, of the home's policies and procedures related to residents' plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, and risks associated with not providing care as per the plan. As a result, the home also failed to maintain the required records of the retraining.

During an interview with PSW #117, they stated that they had not received any training on the home's policies and procedures related to residents' plans of care, or any of the items identified in step (d) of CO #001. The PSW stated that they had not received any specific training, from January 17, 2018, [the date the order was served], to March 30, 2018, [the date the order was due], on the items detailed.

During an interview with RPN #122, they stated that they did not recall the provision of training as detailed in step (d) of CO #001. They elaborated that they could not recall anyone providing the training, sitting down to do training, or receiving a presentation or any papers on the training required in the order.

During an interview with RN #123, they stated that they had informal discussions with staff during huddles regarding care plan changes, but was not able to identify any training specific to step (d) of CO #001 that had been provided.

During an interview with the ADOC, they stated that the home had provided a memo to staff with their pay stubs to address step (d) of the order.

Inspector #625 reviewed the memo dated January 21, 2018, and noted that the memo identified that the home would be taking corrective action and improving the process of development, maintenance and verification of care plans as it was clear that the existing system was flawed. The memo did not include any retraining, of the home's policies and procedures related to residents' plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, or risks associated with not providing care as per the plan.

During an interview with the DOC, they stated that they did not think that the home had completed step (d) of the order and could not recall any actions taken by the home to address that component of the order. During a subsequent interview with the DOC, they acknowledged that the home had not completed step (d) of the order. [s. 6. (7)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment [referred to in O. Reg. 79/10, s. 51 (2) (a)] and that the plan was implemented.

O. Reg. 79/10, s. 51 (2) (a) indicates each resident who is incontinent is to receive an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

CO #001 from inspection #2017_435621_0026 was served pursuant to the LTCHA, 2007, s. 6 (7) on January 17, 2018, with a compliance date of March 30, 2018. The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #001.

Inspector #625 reviewed resident #001's health care record which included the most recent Bladder & Bowel Assessment dated the spring of 2018, which identified the resident had medical conditions which impacted their ability to be continent and that staff were to offer a particular continence intervention as tolerated. The assessment also identified that the resident's care plan was current, no changes were needed and there was a plan/routine in place.

Inspector #625 further reviewed resident #001's health care record which included:
- a PSW worksheet updated October 12, 2018, which identified the staff were to provide a continence related intervention to the resident at particular times;
- PSW worksheets updated October 17 and 18, 2018, both of which identified staff were to provide continence related interventions to the resident at particular times; and
- a care plan titled Continence Care (or Indwelling Catheter) last updated in the fall of 2018, which identified staff were to provide a continence related intervention around particular times.

The Inspector noted that, during the inspection, some of the times listed for the continence related intervention previously listed on the October 12, 2018, PSW worksheet had been removed from subsequent worksheets, resulting in an

increased period of time when the resident was not provided with the continence related intervention.

During an interview with the RAI Coordinator, they stated that they had not been aware of changes made to resident #001's continence interventions in their care plan, that the Bladder & Bowel Assessment they had completed in the spring of 2018 was accurate when it indicated that resident exhibited certain characteristics related to continence. The RAI Coordinator stated that resident #001 waiting for the increased period of time for the continence related intervention would be too long in between receiving the intervention.

During an interview with the DOC, they stated that the ADOC had changed continence related interventions for multiple residents after discussion with staff about the staff's struggle with the intervention times.

During interviews with the ADOC, they acknowledged that resident #001's plan of care no longer indicated they were to be provided with the continence related interventions at all of the times initially listed, and stated the times were changed as the times previously listed were not achievable for staff as they were bunched together. The ADOC identified that they had changed the plans of care related to continence care for six residents on the unit resident #001 resided on, as well as other residents on other units. The ADOC acknowledged that resident #001's plan of care had not been changed based on an assessment of their bladder incontinence, or based on any formal or documented assessment of the resident. [s. 51. (2) (b)]

2. CO #001 from inspection #2017_435621_0026 was served pursuant to the LTCHA, 2007, s. 6 (7) on January 17, 2018, with a compliance date of March 30, 2018. The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care. The findings supporting the order identified that the home had been non-compliant regarding the provision of care related to continence care and bowel management.

Inspector #625 reviewed resident #005's health care record which included the most recent Bladder & Bowel Assessment dated the summer of 2018, which identified the resident had medical conditions which impacted their ability to be continent. The assessment also identified that the resident's care plan was current, and no changes were required.

Inspector #625 reviewed resident #005's health care record which included:
- a PSW worksheet updated October 12, 2018, which identified the staff were to provide a continence related intervention to the resident at particular times;
- PSW worksheets updated October 17 and 18, 2018, both of which identified staff were to provide continence related interventions to the resident at particular times; and
- a care plan titled Continence Care (or Indwelling Catheter) last updated in the fall of 2018, which identified staff were to provide a continence related intervention on or about particular times.

The Inspector noted that, during the inspection, some of the times previously listed for the provision of the continence related intervention on the October 12, 2018, PSW worksheet had been removed from subsequent worksheets, resulting in an increased period of time when the resident was not provided with the continence related intervention.

During an interview with the DOC, they stated that the ADOC had changed the continence related interventions for multiple residents after discussion with staff about the staff's struggle with the intervention times.

During interviews with the ADOC, they acknowledged that resident #005's plan of care was changed, eliminating a time the continence related intervention was to be provided to the resident by the staff, because the resident's spouse could provide that intervention to the resident at that time. The ADOC stated that they did not believe anyone had discussed the resident's spouse's role in providing the continence related intervention to the resident with the spouse, and stated that, if the spouse did not attend the home they "would hope" the resident would be provided with the continence related intervention by staff. The ADOC did not comment on another eliminated time of the scheduled continence related intervention, but stated that the provision of the intervention scheduled for after supper was the intervention to address the resident's bedtime continence intervention. The ADOC identified that multiple residents had changes made to their continence care routines which had not been based on any formal or documented assessments. [s. 51. (2) (b)]

3. CO #001 from inspection #2017_435621_0026 was served pursuant to the LTCHA, 2007, s. 6 (7) on January 17, 2018, with a compliance date of March 30, 2018. The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care. The findings

supporting the order identified that the home had been non-compliant regarding the provision of care related to continence care and bowel management.

Inspector #625 reviewed resident #008's health care record which included the most recent Bladder & Bowel Assessment dated the summer of 2016, which identified the resident had medical conditions which impacted their ability to be continent.

Inspector #625 reviewed resident #008's health care record which included:
- a PSW worksheet updated October 12, 2018, which identified the staff were to provide a continence related intervention to the resident at particular times;
- PSW worksheets updated October 17 and 18, 2018, both of which identified staff were to provide continence related interventions to the resident at particular times and use a particular continence related product intended for night time use, during the day;
- a care plan titled Continence Care last updated in the fall of 2018, which identified the resident had medical conditions which impacted their ability to be continent. The care plan identified the resident was to be provided with a continence related intervention at particular times and that staff were to use a particular continence related product intended for use at night, during the day.

The Inspector noted that, during the inspection, some of the times the continence related interventions were to be provided to the resident, previously listed on the October 12, 2018, PSW worksheet had been removed from subsequent worksheets, resulting in increased periods of time when the resident was not provided with the continence related interventions.

During an interview with PSW #124, they stated that resident #008 should be provided with the continence related intervention more frequently than the revised times.

During an interview with PSW #113, they stated that the elimination of one of the times for resident #008's continence related intervention was probably a mistake and taken out by accident. They stated that the resident would use a night time continence related product during that day to address a consequence of reducing the frequency of the provision of the intervention.

During an interview with RPN #125, they stated the changes to the resident's care plan resulted in the provision of the continence related interventions at a lesser

frequency, was inappropriate, and the resident needed to be provided with the continence related intervention more frequently than what the plan of care had been changed to.

During an interview with the RAI Coordinator, they explained that the green briefs were for night time use and held more urine and that the resident should be provided with the continence related intervention more frequently than what the plan of care had been changed to reflect.

During an interview with the DOC, they stated that the ADOC had changed the continence related interventions for multiple residents after discussion with staff about the staff's struggle with the intervention times. The DOC acknowledged that the changes to the intervention times resulted in an increased period of time when the resident was not provided with the continence related intervention. The DOC stated that the changes to the continence related interventions in the care plan were rash, needed to be relooked at and had not been based on any assessment of the resident's bowel or bladder continence.

During interviews with the ADOC, they acknowledged that resident #008's plan of care had been changed, eliminating scheduled continence related interventions and using a product intended for night time use with the resident during the day. The ADOC acknowledged that staff would not specifically provide the continence related intervention to the resident for a particular period of time. The ADOC identified that multiple residents had changes made to the times they were provided with a continence related intervention because the times previously listed were not achievable for staff as they were bunched together. The ADOC identified that the changes to the plan of care had not been based on any formal or documented assessment of the residents. [s. 51. (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 that ensures that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

Issued on this 8 th day of February, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by TIFFANY BOUCHER (543) - (A1)
Inspection No. / No de l'inspection :	2018_703625_0023 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001569-18 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 08, 2019(A1)
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	Princess Court Princess Street, Box 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Berrey

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:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_435621_0026, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA, 2007.

The licensee shall prepare, submit and implement a plan to ensure that residents #001 and #015, and all residents in the home, are provided with care set out in their plans of care as specified in the plans. The plan must include, but is not limited to, the following:

(a) A written policy and/or procedure which ensure(s) that, for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001 and #015;
(b) An auditing process for residents' plans of care to ensure that all direct care staff provide care as per the plan. The home is to maintain written records of the audits conducted including the dates, times, locations and findings of each audit, as well as any corrective actions, follow-up actions taken to ensure future sustained compliance and the name of the person conducting the audit; and
(c) Retraining of all direct care staff involved in the care of residents in the home including: the home's policies and procedures related to residents' plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care and risks associated with not providing care as per the plan. The home is to maintain a record of the retraining provided, including the date(s) of the retraining, what the retraining entailed (including the specific content of any training materials used) and the names and classifications of staff who completed the retraining.

Please submit the written plan for achieving compliance for inspection 2018_703625_0023 to Katherine Barca, LTC Homes Inspector, MOHLTC, by email to @MOH-G-HSAPD PIC Sudbury SAO by November 26, 2018. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The licensee has failed to comply with CO #001 from inspection #2017_435621_0026 issued on January 17, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #001.

Inspector #625 reviewed resident #001's plan of care, with a focus on falls prevention interventions, including:
- a care plan titled Risk of Injury from Falls, last updated in the summer of 2018, which identified the resident was to have two specific interventions in place, including the use of a personal assistance services devices (PASD); and
- a PSW worksheet, updated October 18, 2018, which identified the resident required a PASD when using their mobility device, and required a second falls prevention intervention.

On a date in the fall of 2018, the Inspector observed resident #001 using their mobility device in the TV lounge without the PASD engaged.

During multiple observations on dates in the fall of 2018, the Inspector noted that the resident did not have the second falls prevention intervention in use.

During an interview with resident #001's family member #116 they stated that [during their regular visits with the resident], the resident did not have the second falls prevention intervention in use, which was also not in use at the time of the interview.

During an interview with PSW #117 in the fall of 2018, they attended the resident with the Inspector and confirmed that their PASD was not engaged. The PSW stated that they believed staff had not applied the resident's PASD when they had asssisted the resident to use their mobility aid.

During an interview with PSW #105 on a date in the fall of 2018, they attended the resident with the Inspector and acknowledged that the PASD for use with their mobility device was not engaged. The PSW also acknowledged that the resident did not have a second falls prevention intervention in place, as was required.

On a date in the fall of 2018, PSW #108 confirmed that resident #001 did not have a second falls prevention intervention in place.

During an interview with the DOC, they identified that the resident should have falls prevention interventions listed in their plan of care, including the use of the second falls prevention intervention, provided as indicated in their plan of care. (625)

2. The licensee has failed to comply with CO #001 from inspection #2017_435621_0026 issued on January 17, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of resident #015.

Inspector #625 reviewed the most recent Quarterly Nutrition Review – Nutrition Assessment, dated in the fall of 2018, which identified that staff were to continue with the current care plan and referred to the nutritional care plan.

The Inspector also reviewed resident #015's care plan titled Nutritional Care, last updated in the fall of 2018, which identified the resident required a particular diet, served in a particular manner, and required staff assistance with eating.

On a date in the fall of 2018, the Inspector observed resident #015 served an item during a meal service that was not consistent with the criteria listed in the resident's care plan.

On a date in the fall of 2018, during an interview with PSW #118 regarding the items they were assisting resident #015 to eat, they acknowledged that the food item did not meet the criteria listed in the care plan. They stated that they were aware that the resident was not supposed to be given food with a certain characteristic, but they were not sure how the actual characteristic of the food item was supposed to be.

On a date in the fall of 2018, during an interview with PSW #119 regarding the food item they had begun to assist the resident with during the meal, the PSW acknowledged that the item they were assisting resident #015 with was of a characteristic opposite to the item characteristic they were to provide to the resident. They stated that they were not sure of the parameters of the characteristic and just served the resident from what the kitchen provided. The PSW stated they were not aware that the resident's care plan identified their food was to be served in a particular manner.

On a date in the fall of 2018, during an interview with Dietary Aide #120 regarding the meal service they had provided to resident #015, they identified that the resident was supposed to have a particular diet with foods served in a particular manner, but that the food item had not been served in that manner due to steps involved in the preparation of the item.

During an interview with PSW #121 on a date in the fall of 2018, during the another meal, the PSW stated that the resident was given a diet of a characteristic that was not consistent with the diet listed in their care plan. (625)

3. The licensee has failed to comply with compliance order #001 from inspection #2017_435621_0026 issued on January 17, 2018, with a compliance date of March 30, 2018.

The licensee was ordered to:
"a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001, #006, #014 and #015;
b) Develop and implement a system to ensure that all direct care staff (PSWs, RPNs, RNs) who are involved in the care of residents, are engaged in the review and revision process of resident's plans of care, and are kept aware of every resident's most up to date plans of care as changes occur;
c) Implement an auditing process for resident's plans of care to ensure that all direct care staff are providing care as per the plan; and
d) Provide retraining to all direct care staff involved in the care of resident's in the home, of the home's policies and procedures related to resident's plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, and risks associated with not providing care as per the plan. The home is to maintain a record of the required retraining, who completed the retraining, when the retraining was completed, and what the retraining entailed."

The licensee completed step (b).

The licensee failed to complete steps (a), (c) and (d).

(A) With respect to step (a), the licensee was required to ensure that for every resident in the home, staff provided care as specified in each resident's plan of care, including the care of residents #001, #006, #014 and #015.

The licensee failed to ensure that staff provided care set out in the plan of care to resident #001 with respect to falls prevention, and resident #015, with respect to nutrition and hydration. Refer to WN #1, findings 3 and 4 for details.

(B) With respect to step (c), the licensee failed to implement an auditing process for residents' plans of care to ensure that all direct care staff provided care as per the plan.

During an interview with Inspector #625, the ADOC stated that they could not recall auditing the provision of resident care as identified in their plans of care, or that any audit records had been maintained. During a subsequent interview with the ADOC, they acknowledged that step (c) of the order had not been completed by the home.

During an interview with the DOC, they stated that they did not recall conducting any audits or maintaining any records of audits. During a subsequent interview with the DOC, they stated that step (c) of the order had not been completed as the home had not audited of the provision of resident care.

(C) With respect to step (d), the licensee failed to provide retraining to all direct care staff involved in the care of residents in the home, of the home's policies and procedures related to residents' plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, and risks associated with not providing care as per the plan. As a result, the home also failed to maintain the required records of the retraining.

During an interview with PSW #117, they stated that they had not received any training on the home's policies and procedures related to residents' plans of care, or any of the items identified in step (d) of CO #001. The PSW stated that they had not received any specific training, from January 17, 2018, [the date the order was served], to March 30, 2018, [the date the order was due], on the items detailed.

During an interview with RPN #122, they stated that they did not recall the provision of training as detailed in step (d) of CO #001. They elaborated that they could not recall anyone providing the training, sitting down to do training, or receiving a presentation or any papers on the training required in the order.

During an interview with RN #123, they stated that they had informal discussions with staff during huddles regarding care plan changes, but was not able to identify any training specific to step (d) of CO #001 that had been provided.

During an interview with the ADOC, they stated that the home had provided a memo to staff with their pay stubs to address step (d) of the order.

Inspector #625 reviewed the memo dated January 21, 2018, and noted that the memo identified that the home would be taking corrective action and improving the process of development, maintenance and verification of care plans as it was clear that the existing system was flawed. The memo did not include any retraining, of the home's policies and procedures related to residents' plans of care, staff responsibilities with respect to providing care as specified in each resident's plan of care, or risks associated with not providing care as per the plan.

During an interview with the DOC, they stated that they did not think that the home had completed step (d) of the order and could not recall any actions taken by the home to address that component of the order. During a subsequent interview with the DOC, they acknowledged that the home had not completed step (d) of the order.

The severity of this issue was determined to be a level two as there was the potential for actual harm to occur. The scope of the issue was a level two as it related to two out of three residents reviewed. The home had a level three history as they had non-compliance related to this section of the LTCHA, 2007, that included a compliance order (CO) issued January 17, 2018 (2017_435621_0026). (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 08, 2019(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 8 th day of February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by TIFFANY BOUCHER (543) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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