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 le Loi de 2007 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 Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 27, 2016;	2016_336620_0020 (A1)	011646-16	Resident Quality Inspection

Licensee/Titulaire de permis

ANSON GENERAL HOSPITAL
58 Anson Dr. IROQUOIS FALLS ON P0K 1E0

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

SOUTH CENTENNIAL MANOR
240 FYFE STREET IROQUOIS FALLS ON P0K 1E0

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

ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home currently has a plan to maintain the security of the drug supply. The home has submitted the plan to Inspector #620. The home currently has hired a contractor to provide a reconfiguration of the medication room to ensure that it meets the requirements of regulation 130 of the LTCHA. After discussion with the SSAO manger the decision was made to grant the home an extension. The compliance date will now be November 28, 2016.

Issued on this 27 day of October 2016 (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

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ALAIN PLANTE (620) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 06-10, 2016, and June 13-17, 2016

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed various home policies, procedures, and programs, reviewed staff education attendance records, and reviewed maintenance records.

The following were also inspected concurrently:

- deferred inspection items related to the home's 2015 Resident Quality Inspection,

- follow-up to an order related to duty to protect,

- follow-up to five orders related to recreation and social activities, bed rails, mandatory staff training, and accommodation and service,

- a critical incident related to resident to resident abuse,

- a critical incident related to a resident fracture with an unknown cause, and

- two critical incidents related to resident falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Chief Nursing Officer (CNO), Directors of Nursing and Personal Care (DOC), Registered Dietitian (RD), Maintenance Manager, Management Account Executive, Physiotherapist, Resident Assessment Instrument (RAI) Co-ordinator, Infection Control Lead, Food Services Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Food Services Workers, residents, and residents' family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

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

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Training and Orientation

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

21 WN(s)
10 VPC(s)
7 CO(s)
1 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 212. (1)	CO #902	2016_336620_0020	620
O.Reg 79/10 s. 213. (1)	CO #901	2016_336620_0020	620
LTCHA, 2007 s. 6. (10)	CO #001	2015_376594_0026	609

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care (DOC) worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

During a Resident Quality Inspection (RQI) it was observed by Inspector #620, #609, and #543 that the Director of Care (DOC) was not present in the home for at least 35 hours.

Inspector #620 interviewed a member of the Family Council. The family council member disclosed that they were a family member to a resident in the home. They stated that an incident had occurred for which they needed to speak with the DOC. They noted that there was no DOC available in the home for an entire week and they were directed by the home's staff to call the Assistant Director of Care at a different home (Rosedale Centre in Matheson).

Inspector #620 (accompanied by Inspector #543) interviewed the DOC. They verified that they were the DOC for three long-term care homes which included South Centennial Manor, Villa Minto, and Rosedale Centre. During the interview with Inspector #620 it was explained that in order to meet the legislative requirement for this home (South Centennial Manor) and the other two homes they would need to work in excess of 60 hours and that they were unable to meet the requirement to be on site in the home for 35 hours per week. [s. 213. (1) 5.]

Additional Required Actions:

CO # - 901 was 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. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.

During the RQI it was observed that the Administrator was not present in the home. In an eight day period it was observed that the Administrator was only present in the home for one half hour.

Inspector #620 interviewed the DOC. The DOC said that the Administrator was based out of Cochrane. The DOC stated that the Administrator also acted as the Chief Executive Officer (CEO) for three hospitals as well as the Administrator for three long-term care homes which included South Centennial Manor, Villa Minto, and Rosedale Centre.

Inspector #620 interviewed the Executive Leader of Clinical Services (ELCS). The ELCS stated that they had performed the role of the Administrator a couple times in their tenure as the ELCS. The ELCS verified that when they served as the Administrator they did not spend their time on site in the home, and that their office location was at a separate facility at the Anson General Hospital. The ELCS said that they had not worked in the home as the Administrator within the last month.

Inspector #620 (accompanied by Inspector #543) interviewed the Administrator. The Administrator verified that they were the CEO for three hospitals as well as the Administrator for three long-term care homes which included South Centennial Manor, Villa Minto, and Rosedale Centre. The Administrator stated that they were not on site at the home for the required 24 hours per week, and that they were unaware of the requirement set out in the LTCHA and Ontario Regulations. The Administrator stated that they were on site in the home "maybe two hours a week." [s. 212. (1) 2.]

Additional Required Actions:

CO # - 902 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of maintenance services for the home.

During inspection #2015_376594_0026, compliance order (CO) #002 was issued to the home related to section 15 of the Long-Term Care Homes Act, 2007, on December 23, 2015; whereby, the state of disrepair of the home was to be addressed.

a) The CO issued indicated that a tub room floor was water damaged and stained and was to be fixed.

Inspector #609 observed significant yellow and brown staining to one of the home's tub room floors.

In an interview with the Maintenance Manager, they said that the floors were cleaned but that the yellow and brown staining could not be removed.

Inspector observed considerable yellow and brown staining to the floors of all three tub rooms not addressed since the CO was issued.

b) During inspection #2015_376594_0026 a CO was issued indicating that the top of a vanity was worn with stains.

Inspector #609 observed that the vanity remained worn with stains.

In an interview with the Maintenance Manager, they said that there was no way to clean the top of the vanity in order to remove the stains.

Inspector observed eight resident bathroom vanities and found that 50 per cent were all worn with white stains.

c) During inspection #2015_376594_0026 a CO was issued indicating that the home was to have ensured there was an organized program of maintenance services for the home and that it was implemented.

In an interview with Inspector #609, the Maintenance Manager was unable to produce any written description of the organized program of maintenance services for the home, and said that they "stay on top of things" through a maintenance log book.

In an interview with the home's previous and now retired Maintenance Manager, they said that the home did not have any schedules or procedures written or otherwise in place for routine, preventive and remedial maintenance.

In an interview with the DOC, they verified that it was the expectation that the required maintenance program for the home should have had a written description of the program; the written description should have contained schedules or procedures in place for routine, preventive and remedial maintenance and that currently there was none. [s. 15. (1) (c)]

Additional Required Actions:

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

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and were not neglected by the licensee or staff.

During inspection #2015_336620_0002, CO #001 was issued. The CO was related to s. 19 (1); whereby, the home was to have ensured that a monitoring process was developed to make certain PSW #101 was prevented from sexually abusing residents in the home as well as retrain and evaluate the retraining of PSW #101 on the home's zero tolerance of abuse policy.

a) In an interview with Inspector #609, the DOC said that PSW #101 returned to direct care work 21 days after the CO was issued to the home to have ensured that a monitoring process was developed to protect residents from sexually abuse. When PSW #101 returned to work, no other staff member was made aware or given the responsibility to supervise their performance. The DOC stated that no one evaluated PSW#101's performance for 108 days, when a co-worker (PSW #102) was asked by the DOC if PSW #101 had exhibited any inappropriate sexual behaviour, following their return to work. In an interview with Inspector #609, PSW #102 revealed that they were unaware of any need for heightened monitoring of PSW #101.

A review of the staffing schedules for PSW #101 and #102 found that 50 per cent of the time they did not work together.

A review of documents provided by the home related to the required monitoring of PSW #101 found that the process was not developed and documented by the DOC until 160 days after CO #001's compliance date had passed.

In the same interview the DOC said they did not monitor PSW #101 as required after they returned to work.

b) Inspector #609 interviewed the DOC; they said that PSW #101 completed the home's zero tolerance of abuse and neglect annual retraining; however, no one re-evaluated their understanding of the retraining.

Inspector #609 reviewed the required retraining for PSW #101 which indicated that they signed a pledge to provide services in a way that was free from abuse/neglect of any kind.

In the same interview, the DOC admitted that despite PSW #101's retraining, they engaged in actions that were not appropriate for a PSW.

c) Inspector #609 reviewed correspondence provided to PSW #101 by the home which indicated that they were not to refer to themselves in a particular way.

During the initial tour of the home the Inspector observed PSW #101 providing care to residents without any identification of their name or designation.

In an interview with PSW #101, they verified that they were not following the home's policy related to proper identification. PSW #101 continued to provide care to residents without to proper identification.

In an interview with the DOC, they said that it was the expectation of the home that staff identified themselves when working in the home verbally as well as by wearing their name tags. The DOC said that PSW #101 was previously reprimanded for identifying themselves in a particular way. The DOC verified that PSW #101 did not identify themselves as was required by the home's policy. [s. 19. (1)]

Additional Required Actions:

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

WN #5: 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 where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

During inspection #2015_376594_0026 CO #002 was issued related to s.15 (1). The home was to have submitted a plan that addressed: The 14 beds that failed the entrapment zone assessment; Develop a process to assess all residents who used bed rails as well as their bed systems and; Ensure that the completed bed rail use assessments were included in each resident's plan of care.

a) In an interview with Inspector #609, the DOC was asked to provide the required plan that was to be submitted to the inspector that addressed bed systems, side rails, and entrapment risk. The DOC was unable to provide the required plan and verified no required plan was developed.

b) In an interview with Inspector #609, the DOC said that the 14 beds that failed the entrapment zone assessments were replaced with new ones.

A review of the entrapment zone assessments for the 14 new beds found all had passed.

Inspector #609 observed three of the new beds purchased by the home and found all three or 100 per cent had mattresses that slid off the frame of the bed when little force was applied.

In an interview with the Manufacturing Account Executive responsible for the 14 new beds, they said that the mattresses were not supposed to slide off the frames when little force was applied, but stay immobile within the bed frames. Otherwise, the bed systems would have failed the entrapment zone assessment.

In an interview with the DOC, they verified that the new mattresses did not securely fit into the bed frames.

c) In an interview with Inspector #609, the DOC said it was the expectation that registered staff completed the resident specific side rail use assessments with every new resident on admission.

A review of the health care records for three residents (#018, #021 and #022) admitted to the home, found no resident specific side rail use assessments were completed.

In interviews, RN #114 and RPN #122 both indicated that they were unaware of any electronic or paper side rail use assessment registered staff were responsible to complete for all residents on admission.

In interviews with RN #125 and RPN #113, both said they were unaware of any resident specific assessment for side rail use that they were responsible to complete.

d) In an interview with Inspector #609, the DOC verified that staff were to follow the Bed Entrapment Prevention program for the home that was based on the "Health Canada Guidance Document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" March 17, 2008.

A review of the "Health Canada Guidance Document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" March 17, 2008, indicated that Health Canada recommended that patients be reassessed for risk of entrapment whenever there was a change in the residents medication or physical condition.

A review of the Bed Entrapment Prevention program policy for the home last updated in July 2015 indicated that registered staff were to evaluate bed entrapment prevention strategies when there was a change in the resident's status.

In the same interview with the DOC, they said that resident specific bed rail use assessments were only completed on admission. The DOC also stated that currently no resident specific reassessment for bed rail use was being completed on residents after a change in their conditions. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including:

- ensuring all areas where drugs were stored were kept locked at all times, when not in use, and

- ensuring access to these areas were restricted to persons who may dispense, prescribe, or administer drugs in the home, and the Administrator.

Inspector #620 observed that the side door to the medication room was unlocked. The Inspector was able to enter the room, upon entering they noted a medication cart was left unattended and unlocked with the keys left in the cart.

On three other occasions Inspector #620 and #543 observed that the medication room was unlocked and unattended with medications stored within.

In other instances, Inspectors #543 and #620 observed several PSWs in the medication room doing their charting. At times, throughout the day, there were no registered staff in the medication room when non-registered staff members were in the room.

During the course of the inspection, Inspector #620 observed resident #013 seated in front of a medication cart, in the medication room. The medication room was attended by a number of registered and non-registered staff; at no time did any of the staff attempt to redirect the resident out of the medication room; rather, the resident left of their own accord.

Inspector #609 interviewed RN #114 who confirmed that the medication room door was unlocked and open and unregistered staff were in the room charting with medications in sight on the medication cart. RN #114 confirmed that the security of the medication room had been a long standing issue.

In an interview with the DOC, the Inspector informed them that the door to the medication room was left unlocked and the medication cart was left unattended and unlocked with the keys left on the cart. The DOC stated that it was the expectation that the medication room be locked at all times and at no time were staff to leave the keys on the medication cart, unattended.

The DOC verified that non-registered staff members could gain access to the medication room. The DOC stated that it was a common work place for registered and non-registered staff members. They also verified that it was a risk to residents. [s. 130.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that training had been provided for all staff who applied physical devices or who monitored residents restrained by physical devices including the application, use, and potential dangers of these physical devices.

During inspection #2015_376594_0026 CO #003 was issued to the home; whereby, the home was to have provided retraining to all staff who applied physical devices including PASDs or who monitored residents with devices including PASDs in the application, use, and potential dangers of the devices.

In an interview with Inspector #609, the DOC said that the Restraint policy was revised on February 4, 2016, and all staff were expected to review the policy,

complete a quiz on the information, and return the quiz to the DOC.

In the same interview with the DOC noted that they were unable to produce any documentation of the completed quizzes and was unable to tell the Inspector how many staff completed the retraining. The DOC verified that the required retraining was not completed for all staff who applied or monitored physical devices including PASDs used with residents. [s. 221. (1)]

2. The licensee has failed to ensure that training had been provided for all direct care staff who provided care to residents in skin and wound care.

During inspection #2015_376594_0026 two COs (CO #003 and #004 related to restraints and responsive behaviours) were issued to the home; whereby, the home was to have provided retraining to all staff who provided direct care to residents in two required programs.

Inspector #609 reviewed the home's required training modules to identify if the home had provided staff with the required retraining in restraints and responsive behaviours. While conducting the review, Inspector #609 identified that there were no documents that indicated that staff had been provided retraining in the home's Skin and Wound Care program.

In interviews with RN #114, #125 and RPN #113, all said that they had not received any retraining in the home's Skin and Wound Care program for more than a year.

In an interview with Inspector #609, the DOC said that no retraining of staff in the home's Skin and Wound Care program occurred for more than a year. [s. 221. (1)]

3. The licensee has failed to ensure that behaviour management training had been provided for all staff who provided direct care to residents.

During inspection #2015_376594_0026 a CO #004 was issued to the home; whereby, the home was to have provided responsive behaviours training to all staff who provided direct care to residents.

Inspector #609 reviewed the home's required training modules and was unable to locate any retraining documents related to behaviour management.

In interviews with RN #114, #125 and RPN #113, all said that they had not received any retraining in responsive behaviours for more than a year.

In an interview with Inspector #609, the DOC said that no retraining of staff in behaviour management occurred since the CO was issued as the policy was still under revision. [s. 221. (2)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

Inspector #620 attempted to locate a unit RN for an interview. Inspector #620 asked RPN #123 if they knew where the RN could be found. RPN #123 stated that there was no RN on site and that the DOC was on call if they needed assistance. RPN #123 stated that this had occurred on two other occasions since they had worked in the home.

Inspector #620 reviewed the home's staffing policy dated June 2013. The staffing policy (policy number was unidentified) stated, "if unable to replace an RN, all attempts will be made to staff the RN with an RPN." The document also stated that, "depending on the skill level, the RPN in the building assumes the role of the nurse in charge in the home in the absence of an RN. The RPN must review the nurse in charge duties. The RPN must call if issues are beyond their scope of practice."

Inspector #620 conducted a review of the RN staffing for a two month period. It was revealed that on two occasions the home did not have an RN on duty and present in the home.

Inspector #620 interviewed the DOC. The DOC stated that, "We don't always replace an RN with an RPN; it is our policy to replace with an RPN." The DOC also said that during a day shift, they may act as the RN if an RN was unavailable. The DOC verified that they were aware of the requirement to ensure that at least one RN was on duty and present in the home at all times. [s. 8. (3)]

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 ensuring that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors that lead to secure outside areas that precluded exit by a resident, including balconies and terraces, were equipped with locks to restrict unsupervised access to those areas by residents.

During the initial tour of the home, Inspector #609 observed a sliding patio door in the A unit kitchenette/family room that could only be secured from the inside by a non-locking latch located on the door frame. This door opened onto the home's secured courtyard.

In an interview with Inspector #609, RN #114 verified that the patio door in the resident accessible A unit kitchenette/family room did not lock and could be opened by residents or anyone else via a simple latch.

In an interview with Inspector #609, the Maintenance Manager verified that the patio door did not lock to restrict unsupervised access. [s. 9. (1) 1.1.]

2. The licensee has failed to ensure that all doors leading to non-residential areas were locked when not being supervised by staff.

Inspector #543 observed the patio door in the A unit kitchenette/family room open and unsupervised for approximately seven minutes. The patio door opened to the home's secure courtyard in which the gate impeding exit from the property was observed unlocked, opened, and unsupervised.

In an interview with Inspector #609, the Maintenance Manager said that all doors leading to non-residential areas were to be kept locked when not being supervised by staff and that staff should not have left the gate open after leaving the courtyard.

In the same interview the Maintenance Manager relocked the gate to prevent exit from the property. [s. 9. (1) 2.]

Additional Required Actions:

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

1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents, and

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not open more than 15 centimetres (cm).

During the initial tour of the home Inspector #609 found all resident room windows that were observed during the tour, opened to the outside greater than 15cm.

In an interview with the Maintenance Manager, they verified that all windows in resident rooms could fully open from a minimum of 40cm to a maximum of 53cm. [s. 16.]

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 ensuring that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

During the initial tour of the home on June 6, 2016, Inspector #609 found no resident-staff communication and response system in the home's resident accessible common room, A unit kitchenette/family room, C unit television room, and the Chapel.

A review of the health care records for resident #018 indicated that on May 21, 2016, they were found in the A unit kitchenette in need of assistance; as a result, another resident went to get help.

In an interview with the RAI-Coordinator, they verified that there was no resident-staff communication and response system in the A unit kitchenette/family room and that when resident #018 needed assistance, they had no way to call for help. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and

wound assessment.

During stage one of the RQI a staff interview revealed that resident #013 had altered skin integrity.

Inspector #543 reviewed resident #013's health care records. The health care record identified that resident #013 had altered skin integrity. The inspector was unable to locate an initial skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Inspector #543 reviewed the home's Skin and Wound Management Care Program Policy-LTC-003, last revised February 4, 2016, which indicated that an initial assessment using a clinically appropriate assessment instrument was required for incidents of altered skin integrity.

In an interview with RPN #104, they stated that they could not provide the initial assessments for resident #013's altered skin integrity.

In an interview with RPN #115, they stated that there should have been an initial assessment completed.

The DOC verified that they were aware that initial assessments and weekly wound assessments were not being completed in the home. [s. 50. (2) (b) (i)]

2. During stage one of the RQI a staff interview revealed that resident #014 had altered skin integrity. This was also identified during the inspector's record review.

Inspector #543 reviewed resident #014's health care records. The health care record identified that resident #014 exhibited altered skin integrity. The inspector was unable to locate an initial skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Inspector #543 reviewed the home's Skin and Wound Management Care Program Policy- LTC-003, last revised February 4, 2016, which identified that wounds required an initial assessment using a clinically appropriate assessment instrument.

An interview with RPN #115 verified that there should have been an initial assessment completed when impaired skin integrity was identified. RPN #115 verified that this had not been completed.

In an interview with RN #114 they were unable to provide the initial skin assessment that was completed for the altered skin integrity for resident #014. RN #114 looked through the online documentation and through the paper chart for resident #014 and was unable to find any documentation.

The DOC stated that they were aware that initial assessments and weekly wound assessments were not being completed in the home. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

During stage one of the RQI a staff interview revealed that resident #013 had altered skin integrity.

The Inspector reviewed the home's Skin and Wound Management Care Program Policy-LTC-003, last revised February 4, 2016, which identified that residents with wounds/ulcers required weekly reassessments to be completed.

In interview with RPN #115 and #119, they verified no weekly reassessments for resident #013's altered skin integrity were completed.

The DOC verified that the initial wound and skin assessments and weekly wound assessments were not being completed. [s. 50. (2) (b) (iv)]

4. During stage one of the RQI a staff interview revealed that resident #014 had altered skin integrity. This was also identified during the inspector's record review.

The Inspector reviewed the home's Skin and Wound Management Care Program Policy- LTC-003, last revised February 4, 2016, which identified that wounds required a weekly reassessment.

A review of resident #014's health care records verified that no documentation regarding the altered skin integrity was completed weekly.

In an interview with RPN #115, they confirmed no weekly documentation of the pressure ulcer to resident #114's altered skin integrity was being completed.

RN #114 identified that no wound reassessment tool or documentation was being completed weekly for resident #114.

The DOC stated that they were aware that initial assessments and weekly wound assessments were not being completed. [s. 50. (2) (b) (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 ensuring that residents (resident #013 and #014) exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours were developed to meet the needs of residents with responsive behaviours.

A critical Incident report (CI) related to alleged resident to resident sexual abuse was reported to the Director. According to the CI, a PSW noticed resident #017 in a resident's room. According to the PSW, resident #017 was displaying responsive behaviours toward resident #020.

Inspector #543 reviewed resident #020's health care records. A Behavioural Assessment for Placement Services (CCAC) form, revealed specific responsive behaviours the resident had exhibited. An Annual Physical Examination note, identified that this resident had a previous history of responsive behaviours directed towards staff and residents.

The Inspector reviewed this resident’s most recent plan of care, which did not include the nature of the resident’s responsive behaviour, written strategies, including techniques and interventions, to prevent, minimize or respond to these responsive behaviours.

Inspector #543 spoke with PSW #110 who revealed that this resident did at times display responsive behaviours.

The Inspector spoke with RN #125 who revealed that they were not aware that this resident had a history of responsive behaviours. They also verified that this resident’s plan of care did not identify the responsive behaviours. [s. 53. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours are developed to meet the needs of resident #017, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the Family Council had advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee should have, within 10 days of receiving the advice, responded to the Family Council in writing.

Inspector #620 conducted an interview with a member of the Family Council. The Family Council member stated that they had experienced difficulty getting timely responses from the home with the Family Council's concerns. The Family Council member stated that they had approached the home with concerns about bathing schedules and the new pharmacy provider; however, they stated that the home did not respond within ten days as was required. They indicated that they had to remind the DOC that they had raised the concern.

Inspector #620 reviewed a response letter addressed to the Family Council President. The letter was thanking the Family Council for their letter which addressed five separate concerns. The response letter to the councils concerns was dated 20 days following the date when the DOC became aware of the Council's concerns.

Inspector #620 was approached by Family Council member #137 as they wanted to address some concerns. The Council member stated that they had approached the home with concerns about the bathing schedule in the home and that "the DOC would not get back to us." They also stated that the concerns were not being addressed in writing. They stated they had to request a response in writing because the home would only respond to the council's concerns verbally, and they did not feel as though the concerns were being addressed.

Inspector #620 interviewed Family Council member #136. The Council member stated that the home did not always respond in time to concerns brought forward by the Family Council. The Council member stated that they had to remind the DOC on a number of occasions to respond to concerns such as protocol for missed baths and the bathing schedule. The Council member stated that they waited, "a long time" for a response to their concern.

Inspector #620 interviewed DOC #200 who verified that they were aware of the requirement to address concerns brought forward by the Family Council within 10 days of receiving the concern. DOC #200 acknowledged that they had not answered the Family Councils concerns within 10 days as was required. [s. 60. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the concerns or recommendations of the Family Council are responded to in writing within 10 days of receiving the Family Council's advice, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were monitored during meals, including residents eating in locations other than dining areas.

During dinner dining observations, Inspector #609 witnessed a meal tray being provided to resident #023 in their room before the dinner meal service began.

During the lunch meal service, the Inspector witnessed a meal tray being provided to resident #007 in their room before the lunch meal service began.

A review of the home's policy titled "Meal Service- Dining Room" last revised June 15, 2016, indicated that if residents were at risk for choking they were to be monitored every five minutes if eating in their rooms.

In an interview, the FSM verified that the home's policy was not in compliance with the Regulation as all residents eating in other locations should have been monitored, not just residents at risk for choking.

In an interview, RPN #113 verified that resident #023 was provided a tray when they did not wish to attend the dining room. RPN #113 said that this was a common practice and that there was no process or procedure in place for monitoring residents during meals in locations other than the dining room.

In an interview, PSW #129 said that personal support staff removed meal trays at the end of the meal services and recorded intake. PSW #129 also stated they were unaware that residents were to be monitored during the meal service. [s. 73. (1) 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 ensuring that residents are monitored during meals, including residents eating in locations other than dining areas, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

During the course of inspection, Inspector #620, observed that a tub room door was unattended and unlocked with the door open. One resident was immediately adjacent to the door. The tub room floor had a container of Arjohunterleigh Disinfectant Cleaner IV which was accessible to residents.

A document review of the home's Material Safety Data Sheets for the identified chemical revealed that Arjohunterleigh Disinfectant Cleaner IV was a chemical classified as a skin corrosive category 1C and an eye corrosive category 1.

Inspector #620 interviewed the DOC who stated that it was the home's expectation that the tub room door was to be locked at all times when unattended. The DOC confirmed that the shower room contained hazardous substances that were within reach of residents. [s. 91.]

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 ensuring that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written record of the annual Infection Prevention and Control Program evaluation.

Inspector #609 reviewed a CI which related to an Enteric outbreak declared by Porcupine Health Unit and submitted to the MOHLTC.

A review of the home's policy titled "Outbreak Management" found that the policy was last reviewed and revised in August 2011.

In an interview with Inspector #609, the Infection Control Lead (ICL) said that the Infection Prevention and Control Program was evaluated at each quarterly meeting. The ICL also stated that they became aware of the need for an annual written evaluation of the Infection Prevention and Control Program and that currently there was no written annual evaluation of the program. [s. 229. (2) (e)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

a. During the medication pass, Inspector #543 observed that RPN #113 and RPN #119 administered medication to a resident and did not perform hand hygiene before administering medication to another resident.

In interviews with Inspector #543, RPN #113 and RPN #119 both said that they were not expected to perform hand hygiene between providing care to residents, unless there was direct contact.

b. Inspector #609 observed PSW #130 transfer a resident with a wheelchair, then clean a table of dirty dishes, finally PSW #130 physically assisted another resident all without performing hand hygiene.

In an interview with Inspector #609 PSW #130 verified they were trained in hand hygiene and that they had not performed hand hygiene as per the home's policy.

A review of the home's policy titled, "Hand Hygiene" last revised May 2011, indicated that staff were to perform hand hygiene: Before initial resident/environment contact; Before any aseptic procedures; After body fluid exposure risk and; After resident/environment contact.

In an interview with Inspector #609, the ICL verified that the lack of hand hygiene observed by Inspector #543 and #609 should not have occurred. [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 ensuring that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented; furthermore, the licensee shall ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

During stage one of the RQI a census review for resident #014 revealed that the resident had altered skin integrity.

A review of resident #014's plan of care identified that the resident was to receive a specific intervention on an established schedule.

The inspector reviewed Point of Care documentation, which verified that no documentation regarding the scheduled intervention existed for resident #004.

In an interview with PSW # 103 they stated that resident #114 had certain assistive devices. PSW #103 stated that they completed the specific intervention on an established schedule. PSW #103 verified that there was no documentation related to the scheduled intervention.

An interview with RN #116, they verified that there was no documentation if a resident received a certain scheduled intervention. They further verified they had never seen any documentation of the scheduled intervention on the Point of Care system. [s. 6. (9) 1.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 100. Every licensee of a long-term care home shall ensure that the written procedures required under section 21 of the Act incorporate the requirements set out in section 101. O. Reg. 79/10, s. 100.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written complaint procedures in place that incorporated the requirements set out in section 101 for dealing with complaints.

Inspector #609 spoke with resident #010's substitute decision maker (SDM), they stated that the resident had personal items go missing. They stated they brought forward their concerns to the RN on shift but did not receive a response. The items were never recovered.

Inspector #620 interviewed a family member. They stated that an incident had occurred for which they needed to speak with the DOC. They noted that there was no DOC available in the home for an entire week and they were directed by the home's staff to call the DOC at a different home. The DOC from the other home addressed some of the concerns brought forward by the Family Council member; however, the South Centennial Manor home never responded to their concern.

Inspector #543 reviewed the home's Patient Relations Process-ADM-103 policy with a review date of March 3, 2016. This policy stated that when a concern/complaint was received, the follow-through and the response to the complainant would be completed as quickly as possible with a target of 30 days for completion. This policy's procedure described, that where possible, concerns/complaints should have been addressed at the point of care or service. Staff members should have attempted to resolve concerns as appropriate to their ability and scope of authority. The Patient Relations Process-ADM-103 stated that despite the preferred strategy to resolve concerns/complaints through personal discussions such as telephones calls or face to face meetings there were times when a written response was required particularly when there were complex issues to document.

A review of the home's Patient Relations Process-ADM-103 policy identified that

the policy had not incorporated the requirements for dealing with complaints according to O. Reg 79/10, s. 101.

Ontario Reg 79/10, s. 101 required that, "Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).
(2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).
(3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).
(4) Subsections (2) and (3) do not apply with respect to verbal complaints that the licensee is able to resolve within 24 hours of the complaint being received. O. Reg. 79/10, s. 101 (4)."

Inspectors #543 and #620 spoke with the DOC, regarding the home's Patient Relations Process-ADM-103 with a review date of March 3, 2016. The DOC verified that their policy needed to be amended and that it had not met the legislative requirements. [s. 100.]

WN #20: 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. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the names of all residents involved in the incident.

A CI related to alleged resident to resident sexual abuse was reported to the Director. According to the CI, a PSW noticed resident #017 expressing sexually inappropriate behaviour toward resident #020.

A review of the CI indicated that an amendment was requested to include the name of the female resident involved in the incident. The Inspector identified that no amendment was made to address the same.

In an interview with the DOC, they verified that the CI was not amended. [s. 104. (1) 2.]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Inspector #543 reviewed CI #599-000004-15 related to a fall that occurred. According to the CI resident #016 fell and required a Physicians order for pain medication.

A review of resident #016's health care record indicated that resident #016 was ordered a medication, to be administered at a specific time.

The Inspector reviewed resident #016's medication administration records for the months for a two month period. The records revealed that the resident had been receiving the medication on daily basis at a different time than was indicated on the Physician's order.

Inspector #543 spoke with RPN #113 who indicated that resident #016 was receiving the medication at a different time than what was indicated on the Physician's order. [s. 131. (2)]

Issued on this 27 day of October 2016 (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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ALAIN PLANTE (620) - (A1)

Inspection No. / No de l'inspection : 2016_336620_0020 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 011646-16 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 27, 2016;(A1)

Licensee / Titulaire de permis :
ANSON GENERAL HOSPITAL
58 Anson Dr., IROQUOIS FALLS, ON, P0K-1E0

LTC Home / Foyer de SLD :
SOUTH CENTENNIAL MANOR
240 FYFE STREET, IROQUOIS FALLS, ON, P0K-1E0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Marissa Dubois

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

To ANSON GENERAL HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee shall ensure the following:

a) that immediate action is taken ensuring that the Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week; in a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week,

b) maintain a record of the hours worked by the Director of Nursing and Personal Care on site, in the home.

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

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Director of Nursing and Personal Care (DOC) worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week.

During a Resident Quality Inspection (RQI) it was observed by Inspector #620, #609, and #543 that the Director of Care (DOC) was not present in the home for at least 35 hours.

Inspector #620 interviewed a member of the Family Council. The family council member disclosed that they were a family member to a resident in the home. They stated that an incident had occurred for which they needed to speak with the DOC. They noted that there was no DOC available in the home for an entire week and they were directed by the home's staff to call the Assistant Director of Care at a different home (Rosedale Centre in Matheson).

Inspector #620 (accompanied by Inspector #543) interviewed the DOC. They verified that they were the DOC for three long-term care homes which included South Centennial Manor, Villa Minto, and Rosedale Centre. During the interview with Inspector #620 it was explained that in order to meet the legislative requirement for this home (South Centennial Manor) and the other two homes they would need to work in excess of 60 hours and that they were unable to meet the requirement to be on site in the home for 35 hours per week.

The decision to issue this compliance order was based on the severity which indicated minimal harm or potential for actual harm, and the scope which was determined to be widespread (620)

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

Jun 30, 2016

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

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee shall ensure:

a) that immediate action is taken to ensure that that the home's Administrator works regularly in that position on site at the home for the following amount of time per week; In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week,

b) that an organizational chart outlining the reporting structure within the home is provided to the Sudbury Service Area Office by the compliance due date.

Grounds / Motifs :

1. The licensee failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.

During the RQI it was observed that the Administrator was not present in the home. In an eight day period it was observed that the Administrator was only present in the home for one half hour.

Inspector #620 interviewed the DOC. The DOC said that the Administrator was based out of Cochrane. The DOC stated that the Administrator also acted as the Chief Executive Officer (CEO) for three hospitals as well as the Administrator for three long-term care homes which included South Centennial Manor, Villa Minto, and Rosedale Centre.

Inspector #620 interviewed the Executive Leader of Clinical Services (ELCS). The ELCS stated that they had performed the role of the Administrator a couple times in their tenure as the ELCS. The ELCS verified that when they served as the Administrator they did not spend their time on site in the home, and that their office location was at a separate facility at the Anson General Hospital. The ELCS said that they had not worked in the home as the Administrator within the last month.

Inspector #620 (accompanied by Inspector #543) interviewed the Administrator. The Administrator verified that they were the CEO for three hospitals as well as the Administrator for three long-term care homes which included South Centennial Manor, Villa Minto, and Rosedale Centre. The Administrator stated that they were not on site at the home for the required 24 hours per week, and that they were unaware of the requirement set out in the LTCHA and Ontario Regulations. The Administrator stated that they were on site in the home "maybe two hours a week."

The decision to issue this compliance order was based on the severity which indicated minimal harm or potential for actual harm, and the scope which was determined to be widespread. (620)

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

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

Jun 30, 2016

Order # /
Ordre no : 001

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

Linked to Existing Order /
Lien vers ordre existant: 2015_376594_0026, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home.
2007, c. 8, s. 15 (1).

Order / Ordre :

The licensee shall:

a) develop and maintain written description of the home's organized program of maintenance services for the home; the program shall include:

1) written schedules and procedures, and

2) descriptions of how routine, preventive and remedial maintenance will be managed.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of maintenance services for the home.

During inspection #2015_376594_0026, compliance order (CO) #002 was issued to the home related to section 15 of the Long-Term Care Homes Act, 2007, on December 23, 2015; whereby, the state of disrepair of the home was to be addressed.

a) The CO issued indicated that a tub room floor was water damaged and stained and was to be fixed.

Inspector #609 observed significant yellow and brown staining to one of the home's tub room floors.

In an interview with the Maintenance Manager, they said that the floors were cleaned but that the yellow and brown staining could not be removed.

Inspector observed considerable yellow and brown staining to the floors of all three tub rooms not addressed since the CO was issued.

b) During inspection #2015_376594_0026 a CO was issued indicating that the top of a vanity was worn with stains.

Inspector #609 observed that the vanity remained worn with stains.

In an interview with the Maintenance Manager, they said that there was no way to clean the top of the vanity in order to remove the stains.

Inspector observed eight resident bathroom vanities and found that 50 per cent were all worn with white stains.

c) During inspection #2015_376594_0026 a CO was issued indicating that the home was to have ensured there was an organized program of maintenance services for the home and that it was implemented.

In an interview with Inspector #609, the Maintenance Manager was unable to produce any written description of the organized program of maintenance services for the home, and said that they "stay on top of things" through a maintenance log book.

In an interview with the home's previous and now retired Maintenance Manager, they said that the home did not have any schedules or procedures written or otherwise in place for routine, preventive and remedial maintenance.

In an interview with the DOC, they verified that it was the expectation that the required maintenance program for the home should have had a written description of the program; the written description should have contained schedules or procedures in place for routine, preventive and remedial maintenance and that currently there was none.

Non-compliance was previously identified under inspection #2015_376594_0026, with a CO and a Director's referral being served December 23, 2015. Inspection #2014_282543_0025, with a CO served on March 01, 2015, Inspection 2013_138151_0028, with a CO served on October 13, 2013, and Inspection #2013_138151_0017, with a CO served on May 28, 2013.

The decision to re-issue this CO was based on the scope which had the potential to affect all residents in the home, the severity which indicated minimal harm or a potential for actual harm and the compliance history which despite previous non-compliance issued including four COs and one Director's referral, non-compliance continued with this section of the legislation. (609)

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

Nov 28, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_336620_0002, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure:

a) that a documented system of monitoring is developed and implemented for PSW #101,

b) retrain and evaluate PSW #101's understanding of the home`s Zero Tolerance of Abuse Policy,

c) Maintain a record of all training, and the dates the training occurred.

Grounds / Motifs :

1. The licensee has failed to ensure that all residents were protected from abuse by anyone and were not neglected by the licensee or staff.

During inspection #2015_336620_0002, CO #001 was issued. The CO was related to s. 19 (1); whereby, the home was to have ensured that a monitoring process was developed to make certain PSW #101 was prevented from sexually abusing residents in the home as well as retrain and evaluate the retraining of PSW #101 on the home's zero tolerance of abuse policy.

a) In an interview with Inspector #609, the DOC said that PSW #101 returned to direct care work 21 days after the CO was issued to the home to have ensured that a

monitoring process was developed to protect residents from sexually abuse. When PSW #101 returned to work, no other staff member was made aware or given the responsibility to supervise their performance. The DOC stated that no one evaluated PSW#101's performance for 108 days, when a co-worker (PSW #102) was asked by the DOC if PSW #101 had exhibited any inappropriate sexual behaviour, following their return to work. In an interview with Inspector #609, PSW #102 revealed that they were unaware of any need for heightened monitoring of PSW #101.

A review of the staffing schedules for PSW #101 and #102 found that 50 per cent of the time they did not work together.

A review of documents provided by the home related to the required monitoring of PSW #101 found that the process was not developed and documented by the DOC until 160 days after CO #001's compliance date had passed.

In the same interview the DOC said they did not monitor PSW #101 as required after they returned to work.

b) Inspector #609 interviewed the DOC; they said that PSW #101 completed the home's zero tolerance of abuse and neglect annual retraining; however, no one re-evaluated their understanding of the retraining.

Inspector #609 reviewed the required retraining for PSW #101 which indicated that they signed a pledge to provide services in a way that was free from abuse/neglect of any kind.

In the same interview, the DOC admitted that despite PSW #101's retraining, they engaged in actions that were not appropriate for a PSW.

c) Inspector #609 reviewed correspondence provided to PSW #101 by the home which indicated that they were not to refer to themselves in a particular way.

During the initial tour of the home the Inspector observed PSW #101 providing care to residents without any identification of their name or designation.

In an interview with PSW #101, they verified that they were not following the home's policy related to proper identification. PSW #101 continued to provide care to residents without to proper identification.

In an interview with the DOC, they said that it was the expectation of the home that staff identified themselves when working in the home verbally as well as by wearing their name tags. The DOC said that PSW #101 was previously reprimanded for identifying themselves in a particular way. The DOC verified that PSW #101 did not identify themselves as was required by the home's policy.

Non-compliance was previously identified under inspection #2015_336620_0002, with a CO being served November 30, 2015.

The decision to re-issue this CO was based on the scope which had the potential to affect all residents in the home, the severity which indicated minimal harm or a potential for actual harm and the compliance history which despite previous non-compliance issued including one CO, non-compliance continued with this section of the legislation. (609)

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

Oct 31, 2016

Order # /
Ordre no : 003

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

Linked to Existing Order /
Lien vers ordre existant: 2015_376594_0026, CO #002;

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:

a) conduct an entrapment assessment of all 14 beds identified during inspection #2015_376594_0026,

b) act on the results of the assessment ensuring that all beds systems meet the manufacturers specifications and the best practice guidelines criteria detailed in the, "Health Canada Guidance Document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards"

c) maintain a record of when the assessments, including the dates and any action taken,

d) conduct and maintain a record of resident specific reassessment for all residents currently utilizing bed rails,

e) revise the home's policy on the use of restraints to ensure that it directs staff to conduct reassessment of residents following a change in their conditions.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to

minimize risk to the resident.

During inspection #2015_376594_0026 CO #002 was issued related to s.15 (1). The home was to have submitted a plan that addressed: The 14 beds that failed the entrapment zone assessment; Develop a process to assess all residents who used bed rails as well as their bed systems and; Ensure that the completed bed rail use assessments were included in each resident's plan of care.

a) In an interview with Inspector #609, the DOC was asked to provide the required plan that was to be submitted to the inspector that addressed bed systems, side rails, and entrapment risk. The DOC was unable to provide the required plan and verified no required plan was developed.

b) In an interview with Inspector #609, the DOC said that the 14 beds that failed the entrapment zone assessments were replaced with new ones.

A review of the entrapment zone assessments for the 14 new beds found all had passed.

Inspector #609 observed three of the new beds purchased by the home and found all three or 100 per cent had mattresses that slid off the frame of the bed when little force was applied.

In an interview with the Manufacturing Account Executive responsible for the 14 new beds, they said that the mattresses were not supposed to slide off the frames when little force was applied, but stay immobile within the bed frames. Otherwise, the bed systems would have failed the entrapment zone assessment.

In an interview with the DOC, they verified that the new mattresses did not securely fit into the bed frames.

c) In an interview with Inspector #609, the DOC said it was the expectation that registered staff completed the resident specific side rail use assessments with every new resident on admission.

A review of the health care records for three residents (#018, #021 and #022) admitted to the home, found no resident specific side rail use assessments were completed.

In interviews, RN #114 and RPN #122 both indicated that they were unaware of any electronic or paper side rail use assessment registered staff were responsible to complete for all residents on admission.

In interviews with RN #125 and RPN #113, both said they were unaware of any resident specific assessment for side rail use that they were responsible to complete.

d) In an interview with Inspector #609, the DOC verified that staff were to follow the Bed Entrapment Prevention program for the home that was based on the "Health Canada Guidance Document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" March 17, 2008.

A review of the "Health Canada Guidance Document, Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" March 17, 2008, indicated that Health Canada recommended that patients be reassessed for risk of entrapment whenever there was a change in the residents medication or physical condition.

A review of the Bed Entrapment Prevention program policy for the home last updated in July 2015 indicated that registered staff were to evaluate bed entrapment prevention strategies when there was a change in the resident's status.

In the same interview with the DOC, they said that resident specific bed rail use assessments were only completed on admission. The DOC also stated that currently no resident specific reassessment for bed rail use was being completed on residents after a change in their conditions.

Non-compliance was previously identified under inspection #2015_376594_0026, with a CO being served December 21, 2015. Inspection #2014_282543_0025, with a Written Notice (WN) served on October 07, 2014.

The decision to re-issue this CO was based on the scope which had the potential to affect more than the fewest number of residents, the severity which indicated minimal harm or a potential for actual harm and the compliance history which despite previous non-compliance issued including one CO and one WN, non-compliance continued with this section of the legislation. (609)

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

Ministère 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

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

Nov 28, 2016

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

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

2. Access to these areas shall be restricted to,

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

ii. the Administrator.

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

Order / Ordre :

The licensee shall ensure that the home's current drugs storage area will be used exclusively for drugs.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including:

- ensuring all areas where drugs were stored were kept locked at all times, when not in use, and

- ensuring access to these areas were restricted to persons who may dispense, prescribe, or administer drugs in the home, and the Administrator.

Inspector #620 observed that the side door to the medication room was unlocked. The Inspector was able to enter the room, upon entering they noted a medication cart was left unattended and unlocked with the keys left in the cart.

On three other occasions Inspector #620 and #543 observed that the medication room was unlocked and unattended with medications stored within.

In other instances, Inspectors #543 and #620 observed several PSWs in the medication room doing their charting. At times, throughout the day, there were no registered staff in the medication room when non-registered staff members were in the room.

During the course of the inspection, Inspector #620 observed resident #013 seated in front of a medication cart, in the medication room. The medication room was attended by a number of registered and non-registered staff; at no time did any of the staff attempt to redirect the resident out of the medication room; rather, the resident left of their own accord.

Inspector #609 interviewed RN #114 who confirmed that the medication room door was unlocked and open and unregistered staff were in the room charting with medications in sight on the medication cart. RN #114 confirmed that the security of the medication room had been a long standing issue.

In an interview with the DOC, the Inspector informed them that the door to the medication room was left unlocked and the medication cart was left unattended and unlocked with the keys left on the cart. The DOC stated that it was the expectation that the medication room be locked at all times and at no time were staff to leave the keys on the medication cart, unattended.

The DOC verified that non-registered staff members could gain access to the medication room. The DOC stated that it was a common work place for registered and non-registered staff members. They also verified that it was a risk to residents.

Non-compliance was previously identified under inspection #2015_376594_0026, with a VPC being served August 21, 2015.

The decision to issue this compliance order was based on the scope which had the potential to affect all residents in the home, the severity which indicated minimal harm or a potential for actual harm and the compliance history which despite previous non-compliance issued including one VPC, non-compliance continued with this section of the legislation. (620)

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

Nov 28, 2016(A1)

Order # /
Ordre no : 005

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

Linked to Existing Order /
Lien vers ordre existant:

2015_376594_0026, CO #003;
2015_376594_0026, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall:

a) provide training to all staff who apply physical devices including PASDs or who monitor residents with devices including PASDs in the application, use and potential dangers of the devices,

b) provide training for all direct care staff on the home's skin and wound care program,

c) provide responsive behaviour management training for all direct care staff on the home's responsive behaviour program, and

d) maintain a record of who attended the training, when the training occurred, and what training materials were utilized as a result of this order.

Grounds / Motifs :

1. The licensee has failed to ensure that training had been provided for all staff who applied physical devices or who monitored residents restrained by physical devices including the application, use, and potential dangers of these physical devices.

During inspection #2015_376594_0026 CO #003 was issued to the home; whereby, the home was to have provided retraining to all staff who applied physical devices including PASDs or who monitored residents with devices including PASDs in the application, use, and potential dangers of the devices.

In an interview with Inspector #609, the DOC said that the Restraint policy was revised on February 4, 2016, and all staff were expected to review the policy, complete a quiz on the information, and return the quiz to the DOC.

In the same interview with the DOC noted that they were unable to produce any documentation of the completed quizzes and was unable to tell the Inspector how many staff completed the retraining. The DOC verified that the required retraining was not completed for all staff who applied or monitored physical devices including PASDs used with residents. (609)

2. The licensee has failed to ensure that training had been provided for all direct care staff who provided care to residents in skin and wound care.

During inspection #2015_376594_0026 two COs (CO #003 and #004 related to restraints and responsive behaviours) were issued to the home; whereby, the home was to have provided retraining to all staff who provided direct care to residents in two required programs.

Inspector #609 reviewed the home's required training modules to identify if the home had provided staff with the required retraining in restraints and responsive behaviours. While conducting the review, Inspector #609 identified that there were no documents that indicated that staff had been provided retraining in the home's Skin and Wound Care program.

In interviews with RN #114, #125 and RPN #113, all said that they had not received any retraining in the home's Skin and Wound Care program for more than a year.

In an interview with Inspector #609, the DOC said that no retraining of staff in the home's Skin and Wound Care program occurred for more than a year.
(609)

3. The licensee has failed to ensure that behaviour management training had been provided for all staff who provided direct care to residents.

During inspection #2015_376594_0026 a CO #004 was issued to the home; whereby, the home was to have provided responsive behaviours training to all staff who provided direct care to residents.

Inspector #609 reviewed the home's required training modules and was unable to locate any retraining documents related to behaviour management.

In interviews with RN #114, #125 and RPN #113, all said that they had not received any retraining in responsive behaviours for more than a year.

In an interview with Inspector #609, the DOC said that no retraining of staff in behaviour management occurred since the CO was issued as the policy was still under revision.

Non-compliance was previously identified under inspection #2014_282543_0025, with a VPC being served October 07, 2014, and inspection #2015_376594_0026, with two COs served on December 21, 2015.

The decision to re-issue this compliance order was based on the scope which had the potential to affect all residents in the home, the severity which indicated minimal harm or a potential for actual harm and the compliance history which despite previous non-compliance issued including two compliance orders and one VPC, non-compliance continued with this section of the legislation. (609)

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

Nov 28, 2016

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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
Toronto ON M5S 2B1
Télécopieur : 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 27 day of October 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ALAIN PLANTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury