Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 30, 2015	2015_264609_0053	012496-15	Follow up

Licensee/Titulaire de permis

ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE
70 Spine Road ELLIOT LAKE ON P5A 1X2

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

ST. JOSEPH'S MANOR
70 SPINE ROAD ELLIOT LAKE ON P5A 1X2

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 13, 14, 15, 16, 2015

This inspection was completed in order to follow-up on orders issued to the home from the Resident Quality Inspection (RQI) conducted in February 2015.

A complaint #010044-15 and Critical Incident #005164-15 inspection was also completed concurrently with the follow up by inspector #620.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (Administrator), one Assistant to the Administrator (AA), two Registered Nurses (RN), three Registered Practical Nurses (RPN), eight Personal Support Workers (PSW) and one Substitute Decision Maker (SDM) for a resident.

The inspector(s) also reviewed clinical records, internal investigation reports, complaint reports, critical incident reports, the home's policies and procedures as well as training logs, maintenance logs and components of employee human resource files.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Minimizing of Restraining
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **1 VPC(s)**
- **6 CO(s)**
- **7 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. 110.	WN	2015_331595_0003	609
O.Reg 79/10 s. 110. (7)	CO #008	2015_331595_0003	609
O.Reg 79/10 s. 96.	WN	2015_331595_0003	609
O.Reg 79/10 s. 96.	CO #006	2015_331595_0003	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s.6.(1)(c).

a) Observations made throughout a specified day revealed an identified resident outside the main entrance of the home, alone and unattended.

A review of the plan of care for the identified resident instructed staff not to allow the resident outside without supervision.

An interview with registered staff confirmed that the identified resident was permitted to go outside alone and unattended and confirmed that the plan of care was not clear.

An interview with the Administrator confirmed that it was the expectation of the home that the written plan of care set out clear direction to staff and others who provide direct care to the resident, that the plan of care for the identified resident did not give clear direction related to interventions for the resident when outside and should have.

b) A review of the plan of care for an identified resident revealed two dietary interventions.

An interview with a registered staff member revealed she was unsure when the identified resident was to receive which type of dietary intervention. The registered staff member confirmed that the plan of care related to the specified dietary interventions for the identified resident was not clear.

An interview with the AA confirmed that it was the expectation of the home that the plan of care sets out clear direction to staff and others who provide care, that the plan of care for the identified resident was unclear and should not have been.

The scope of this issue was a pattern of resident plans of care not providing clear direction to staff providing care. There was a previous on-going compliance order issued related to this. The severity was determined to be potential harm to the health, safety and well-being of residents of the home. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 007 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s.15 (2) which specified that the resident and staff communication response system in an identified resident room was to be in a good state of repair and functioning.

Observations made on a specified day of the identified resident room revealed the call bell at the bedside did not activate when pushed, the call bell cord and the control box was broken, the resident's VERSUS badge did not activate when triggered and the bathroom call bell did not activate when pushed.

Observations made on a specified day of the call bell system in another resident room revealed a malfunctioning call light, a broken call bell and when the call bell at the bedside was pushed it did not activate to alert staff to the call.

An interview with registered staff revealed the communication and response system in an identified resident room had not functioned properly for a specified time frame.

A review of the maintenance logs for the unit revealed no tracking of the communication and response system failure in order to correct the malfunctions.

An interview with the Administrator revealed that it was the expectation of the home that all equipment was to be kept in a good state of repair and that it was the expectation of staff to submit a requisition for equipment in disrepair. The Administrator confirmed that the home's communication and response system was not in a good state of repair and should be and that staff did not identify the disrepair to the home in order to correct.

The scope of this issue was a pattern of disrepair to the communication and response system in the home. There was a previous on-going compliance order issued related to this. The severity was determined to be potential harm to the health, safety and well-being of the residents of the home. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 002 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 #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 all residents were protected from abuse by anyone and not neglected by the licensee or staff.

During a previous inspection, #2015-331595-0003 a compliance order was issued for s.19(1) whereby all direct care staff were to be retrained regarding hourly monitoring of residents to ensure that care was provided to all residents on every shift to ensure residents were protected from neglect by staff.

A review of the direct care staff education list related to hourly monitoring revealed 40 of 62 direct care staff members or 65 per cent of the direct care staff listed did not complete the required training.

Three PSWs cited in the compliance order from a previous inspection, #2015-331595-0003 which precipitated the need for additional training, did not complete the required training.

Another Critical Incident Report was submitted to the Ministry which verified another incident of neglect occurred to a resident that involved one of the same staff members cited previously.

A review of the zero tolerance of abuse and neglect retraining for staff revealed that the staff member involved in two confirmed incidents of neglect did not complete the required retraining.

An interview with the Administrator confirmed that it was the expectation of the home that all training and retraining was to be completed by all direct care staff to ensure all residents were protected from abuse by anyone and not neglected by the staff, that all direct care staff did not complete the required training and retraining and should have and in the case of the staff member involved in two Critical Incidents related to neglect of residents, did not complete the retraining and should have. [s. 19. (1)]

2. A complaint was submitted to the Ministry related to personal care provided to residents at night time from the SDM for an identified resident.

A review of the home's internal investigation of the allegations of neglect was verified by the licensee, resulting in disciplinary actions against personal support staff.

A review of the three employee files revealed that one of the PSWs who was involved in the incident cited previously had two prior written warnings related to neglect.

An interview with the Administrator confirmed that it was the expectation of the home that the home’s policy on zero tolerance for abuse and neglect of residents be complied with by staff. The home’s policy stated that neglect was defined as a failure to provide a resident with the care, services or assistance required for health. The home confirmed that identified resident was neglected and that the home did not protect the resident from neglect by staff and should have. [s. 19. (1)]

3. A Critical Incident Report (CI) was submitted to the Ministry which indicated an identified resident had a physical altercation with another resident resulting in injury.

A review of the clinical record for the identified resident for a specified time frame revealed many instances of physically responsive behaviour with nearly half of the instances being directed towards other residents.

The plan of care for the identified resident revealed no interventions were identified that would safeguard against potentially harmful interactions between the identified resident and the other residents of the home.

An interview with the Administrator revealed that no changes were made to the monitoring of the identified resident following the CI. The Administrator confirmed that the identified resident had no involvement with specialized services following the CI to ensure a collaborative approach to assess and develop interventions.

An interview with the Administrator confirmed that other residents of the home were not safe from the responsive behaviours of the identified resident. The Administrator confirmed that it was the home's expectation and policy to ensure that all residents were protected from abuse by anyone, that in the case of the recurring harmful interactions of the identified resident towards other residents this did not occur and should have.

The scope of this issue was a pattern of staff not completing training in abuse and neglect as well as a lack of required retraining of staff members implicated in occurrences of abuse and neglect of residents. There was a previous on-going compliance order issued related to this. The severity was determined to be actual harm occurred to the health, safety and well-being of the residents of the home. (620) [s. 19. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – 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.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraint plan of care includes alternatives to restraining that were considered, and tried, but have not been effective to address the risk to the resident.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s. 31(2) 2. related to alternatives to restraints not trialled.

Observations of an identified resident revealed a specified intervention applied to the resident while ambulating.

A review of the plan of care for the identified resident revealed no mention of the use of the specified intervention.

A review of the clinical record for the identified resident revealed no alternatives to the specified intervention were considered or tried prior to the initiation of the intervention.

An interview with the Administrator confirmed that it was the home's expectation that alternatives to the specified intervention were to be considered and trialled prior to the initiation of the intervention, that in the case of the specified intervention applied to the identified resident this did not occur and should have.

The scope of this issue was isolated to the one resident observed with the specified intervention without trialled alternatives. There was a previous on-going compliance order issued related to this. The severity was determined to be actual harm or risk of harm to the health, safety and well-being of the identified resident and any other resident of the home with the specified intervention being initiated without alternatives being trialled. [s. 31. (2) 2.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: 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. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered staff who was permitting the administration of topical medications by a staff member not otherwise permitted to administer topical medication was satisfied that the staff member could safely administer the topical.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s. 131. (4) related to PSW training in the administration of topical medications.

An interview with a member of the registered staff confirmed that they permit PSWs to administer topical medications to residents.The registered staff member confirmed that they have never assessed whether they were satisfied that the PSWs delegated the task of administering topical medications were safe.

An interview with personal support staff confirmed they have never received an assessment for safety by registered staff who delegated administration of topical medications prior to administering to residents.

An interview with the Administrator confirmed that it was the expectation of the home that if the member of the registered staff was permitting the administration of topical medications by PSWs, the registered staff member was to assess the PSWs and be satisfied that the PSW could safely administer the topical, that the registered staff were not performing an assessment of safety prior to permitting the PSWs to administer topical medications to each specific resident and should be.

The scope of this issue was widespread to all residents in the home requiring topical medication administration. There was a previous on-going compliance order issued related to this. The severity was determined to be potential harm or risk of harm to the health, safety and well-being of all residents of the home requiring topical medication administration. [s. 131. (4) (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 006 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any alleged or suspected incidents of neglect of a resident by the licensee or staff was immediately report to the Director.

During the course of the inspection, a concurrent Critical Incident inspection was completed by inspector #620.

During a previous inspection #2015-331595-0003, a compliance order was issued for s. 24.(1).

A Critical Incident Report was submitted to the Ministry which alleged staff to resident neglect. There was a 40 hour gap between the incident and submission to the Ministry.

An interview with the Administrator confirmed that it was the expectation of the home that any alleged or suspected incidents of neglect of a resident was to be immediately reported to the Director, that in the case of the Critical Incident Report cited this did not occur and should have.

The scope of this issue was isolated to the resident involved in the Critical Incident Report that was not reported immediately to the Director. There was a previous on-going compliance order issued related to this. The severity was determined to be actual risk of harm to the health, safety and well-being of the resident. (620) [s. 24. (1)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 215. Criminal reference check

Specifically failed to comply with the following:

s. 215. (1) This section applies where a criminal reference check is required before a licensee hires a staff member or accepts a volunteer as set out in subsection 75 (2) of the Act. O. Reg. 79/10, s. 215 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a criminal reference check is obtained before a licensee hires a staff member.

A review of the human resource file for an identified personal support worker implicated in two verified allegations of neglect of residents revealed a photocopy of the criminal reference check. The photocopy was missing the second page and could not confirm the results of the criminal reference check for the cited PSW.

A review of the home's policy titled "Background Identity Checks" last revised January 31, 2014, policy #PRS I-b-30, revealed no mention that potential employees of the home were required to provide a criminal reference check that was:

a) Conducted by a police force;
b) Conducted within six months before the staff member was hired and;
c) Provided a vulnerable sector screen to determine the person's suitability.

An interview with the Administrator confirmed that it was the expectation of the home that the home was to obtain a criminal reference check before a licensee hired a staff member, that in the case of the PSW implicated in two verified allegations of neglect this did not occur and should have. [s. 215. (1)]

Additional Required Actions:

DR # 005 – The above written notification is also being referred to the Director for further action by the Director.

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a criminal reference check was obtained before a licensee hired a staff member, to be implemented voluntarily.

Issued on this 2nd day of December, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2015_264609_0053
Log No. / Registre no:	012496-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 30, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE 70 Spine Road, ELLIOT LAKE, ON, P5A-1X2
LTC Home / Foyer de SLD :	ST. JOSEPH'S MANOR 70 SPINE ROAD, ELLIOT LAKE, ON, P5A-1X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	WILMA FLINKERT

To ST. JOSEPH'S GENERAL HOSPITAL ELLIOT LAKE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0003, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall:

a) Ensure that the plan of care set out clear directions to staff and others who provide direct care to a resident.

b) Ensure the plan of care for all residents who exit independently from the home without supervision provides clear directions to staff related to monitoring the resident's health, safety and well-being.

c) Ensure the plan of care for all residents provides clear direction to staff and others providing fluids as to the correct fluid consistency to be provided to residents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s.6.(1)(c).

a) Observations made throughout a specified day revealed an identified resident outside the main entrance of the home, alone and unattended.

A review of the plan of care for the identified resident instructed staff not to allow the resident outside without supervision.

An interview with registered staff confirmed that the identified resident was permitted to go outside alone and unattended and confirmed that the plan of care was not clear.

An interview with the Administrator confirmed that it was the expectation of the home that the written plan of care set out clear direction to staff and others who provide direct care to the resident, that the plan of care for the identified resident did not give clear direction related to interventions for the resident when outside and should have.

b) A review of the plan of care for an identified resident revealed two dietary interventions.

An interview with a registered staff member revealed she was unsure when the identified resident was to receive which type of dietary intervention. The registered staff member confirmed that the plan of care related to the specified dietary interventions for the identified resident was not clear.

An interview with the AA confirmed that it was the expectation of the home that the plan of care sets out clear direction to staff and others who provide care, that the plan of care for the identified resident was unclear and should not have been.

The scope of this issue was a pattern of resident plans of care not providing clear direction to staff providing care. There was a previous on-going compliance order issued related to this. The severity was determined to be potential harm to the health, safety and well-being of residents of the home. [s. 6. (1) (c)] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0003, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall:

a) Ensure the home's communication and response system is maintained in a safe condition and in a good state of repair and is functioning correctly.

b) Ensure on-going testing of the communication and response system is completed, maintain records of the testing and any interventions required to correct malfunctions.

c) Ensure training and retraining of staff include education of the home's policies and procedures related to maintaining the home in a safe condition and in a good state of repair.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s.15 (2) which specified that the resident and staff communication response system in an identified resident room was to be in a good state of repair and functioning.

Observations made on a specified day of the identified resident room revealed the call bell at the bedside did not activate when pushed, the call bell cord and the control box was broken, the resident's VERSUS badge did not activate when triggered and the bathroom call bell did not activate when pushed.

Observations made on a specified day of the call bell system in another resident room revealed a malfunctioning call light, a broken call bell and when the call bell at the bedside was pushed it did not activate to alert staff to the call.

An interview with registered staff revealed the communication and response system in an identified resident room had not functioned properly for a specified time frame.

A review of the maintenance logs for the unit revealed no tracking of the communication and response system failure in order to correct the malfunctions.

An interview with the Administrator revealed that it was the expectation of the home that all equipment was to be kept in a good state of repair and that it was the expectation of staff to submit a requisition for equipment in disrepair. The Administrator confirmed that the home's communication and response system was not in a good state of repair and should be and that staff did not identify the disrepair to the home in order to correct.

The scope of this issue was a pattern of disrepair to the communication and response system in the home. There was a previous on-going compliance order issued related to this. The severity was determined to be potential harm to the health, safety and well-being of the residents of the home. [s. 15. (2) (c)] (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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0003, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 must prepare, submit and implement a plan for achieving compliance with the LTCHA, 2007 S.O. 2007, c. 8, s. 19 (1) all residents are protected from abuse by anyone and not neglected by the licensee or staff.

The plan must include all evaluations and interventions the home performs to ensure residents are free from abuse by anyone and that residents are not neglected by the licensee or staff.

The plan must include how the home will maintain a record of the retraining and heightened monitoring of all staff implicated in any occurrences of abuse or neglect of residents presently and in the future to ensure the health, safety and well-being of residents from the staff verified to have abused or neglected residents.

The plan must include how the home will ensure that all staff complete the mandatory training and retraining of staff in the home's policies and procedures regarding zero tolerance of abuse and neglect as well as mandatory reporting upon hiring and annually thereafter.

Please submit the plan, in writing, to Chad Camps, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, by email at chad.camps@ontario.ca, by December 5, 2015.

Grounds / Motifs :

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

A Critical Incident Report (CI) was submitted to the Ministry which indicated an identified resident had a physical altercation with another resident resulting in injury.

A review of the clinical record for the identified resident for a specified time frame revealed many instances of physically responsive behaviour with nearly half of the instances being directed towards other residents.

The plan of care for the identified resident revealed no interventions were identified that would safeguard against potentially harmful interactions between the identified resident and the other residents of the home.

An interview with the Administrator revealed that no changes were made to the monitoring of the identified resident following the CI. The Administrator confirmed that the identified resident had no involvement with specialized services following the CI to ensure a collaborative approach to assess and develop interventions.

An interview with the Administrator confirmed that other residents of the home were not safe from the responsive behaviours of the identified resident. The Administrator confirmed that it was the home's expectation and policy to ensure that all residents were protected from abuse by anyone, that in the case of the recurring harmful interactions of the identified resident towards other residents this did not occur and should have.

The scope of this issue was a pattern of staff not completing training in abuse and neglect as well as a lack of required retraining of staff members implicated in occurrences of abuse and neglect of residents. There was a previous on-going compliance order issued related to this. The severity was determined to be actual harm occurred to the health, safety and well-being of the residents of the home. (620) [s. 19. (1)] (609)

2. A complaint was submitted to the Ministry related to personal care provided to residents at night time from the SDM for an identified resident.

A review of the home's internal investigation of the allegations of neglect was

verified by the licensee, resulting in disciplinary actions against personal support staff.

A review of the three employee files revealed that one of the PSWs who was involved in the incident cited previously had two prior written warnings related to neglect.

An interview with the Administrator confirmed that it was the expectation of the home that the home's policy on zero tolerance for abuse and neglect of residents be complied with by staff. The home's policy stated that neglect was defined as a failure to provide a resident with the care, services or assistance required for health. The home confirmed that identified resident was neglected and that the home did not protect the resident from neglect by staff and should have. [s. 19. (1)] (609)

3. During a previous inspection, #2015-331595-0003 a compliance order was issued for s.19(1) whereby all direct care staff were to be retrained regarding hourly monitoring of residents to ensure that care was provided to all residents on every shift to ensure residents were protected from neglect by staff.

A review of the direct care staff education list related to hourly monitoring revealed 40 of 62 direct care staff members or 65 per cent of the direct care staff listed did not complete the required training.

Three PSWs cited in the compliance order from a previous inspection, #2015-331595-0003 which precipitated the need for additional training, did not complete the required training.

Another Critical Incident Report was submitted to the Ministry which verified another incident of neglect occurred to a resident that involved one of the same staff members cited previously.

A review of the zero tolerance of abuse and neglect retraining for staff revealed that the staff member involved in two confirmed incidents of neglect did not complete the required retraining.

An interview with the Administrator confirmed that it was the expectation of the home that all training and retraining was to be completed by all direct care staff to ensure all residents were protected from abuse by anyone and not neglected

by the staff, that all direct care staff did not complete the required training and retraining and should have and in the case of the staff member involved in two Critical Incidents related to neglect of residents, did not complete the retraining and should have. [s. 19. (1)] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0003, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with the LTCHA, 2007 S.O. 2007, c. 8, s.31.(2) alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk.

The plan must include a record of an audit of all residents in the home to ensure all restraints being used in the home have been assessed for alternatives to restraining, what alternatives were trialled and the effectiveness of the alternatives and maintain a record of the assessments required.

The plan must include what restraint training and retraining is provided to staff regarding restraint assessment, use and evaluation, how and by what timeframe the home will have the training completed and maintain a record of the restraint training and retraining to ensure restraints are only used after all requirements under the Act have been satisfied.

Please submit the plan, in writing, to Chad Camps, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, by email at chad.camps@ontario.ca, by December 5, 2015.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the restraint plan of care includes alternatives to restraining that were considered, and tried, but have not been effective to address the risk to the resident.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s. 31(2) 2. related to alternatives to restraints not trialled.

Observations of an identified resident revealed a specified intervention applied to the resident while she ambulated.

A review of the plan of care for the identified resident revealed no mention of the use of the specified intervention.

A review of the clinical record for the identified resident revealed no alternatives to the specified intervention were considered or tried prior to the initiation of the intervention.

An interview with the Administrator confirmed that it was the home's expectation that alternatives to the specified intervention were to be considered and trialled prior to the initiation of the intervention, that in the case of the specified intervention applied to the identified resident this did not occur and should have.

The scope of this issue was isolated to the one resident observed with the specified intervention without trialled alternatives. There was a previous on-going compliance order issued related to this. The severity was determined to be actual harm or risk of harm to the health, safety and well-being of the identified resident and any other resident of the home with the specified intervention being initiated without alternatives being trialled. [s. 31. (2) 2.] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 005

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0003, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,

(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;

(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and

(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Order / Ordre :

The licensee shall:

a) Ensure that a registered nursing staff member who is permitting the administration of a topical medication to a resident by a member of the staff who is otherwise not permitted to administer a drug only after he/she is satisfied that the staff member can safely administer the topical medication.

b) Maintain a record of the training performed by the Registered staff to the specific Personal Support staff outlining the resident specific training on the administration of the topical medication and if the Registered staff was satisfied the Personal Support staff was safe to administer the topical.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a member of the registered staff who was permitting the administration of topical medications by a staff member not otherwise permitted to administer topical medication was satisfied that the staff member could safely administer the topical.

During a previous inspection, #2015-331595-0003, a compliance order was issued for s. 131. (4) related to PSW training in the administration of topical medications.

An interview with a member of the registered staff confirmed that she permits PSWs to administer topical medications to residents.The registered staff member confirmed that she has never assessed whether she was satisfied that the PSWs delegated the task of administering topical medications were safe.

An interview with personal support staff confirmed they have never received an assessment for safety by registered staff who delegated administration of topical medications prior to administering to residents.

An interview with the Administrator confirmed that it was the expectation of the home that if the member of the registered staff was permitting the administration of topical medications by PSWs, the registered staff member was to assess the PSWs and be satisfied that the PSW could safely administer the topical, that the registered staff were not performing an assessment of safety prior to permitting the PSWs to administer topical medications to each specific resident and should be.

The scope of this issue was widespread to all residents in the home requiring topical medication administration. There was a previous on-going compliance order issued related to this. The severity was determined to be potential harm or risk of harm to the health, safety and well-being of all residents of the home requiring topical medication administration. [s. 131. (4) (b)] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2015_331595_0003, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee shall:

a) Ensure a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident is to immediately report the suspicion and the information upon which it is based to the Director.

b) Ensure training and retraining for all staff include training related to the mandatory duty to report all alleged or suspected abuse or neglect of residents and to maintain a record of all staff who completed the training.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that any alleged or suspected incidents of neglect of a resident by the licensee or staff was immediately report to the Director.

During the course of the inspection, a concurrent Critical Incident inspection was completed by inspector #620.

During a previous inspection #2015-331595-0003, a compliance order was issued for s. 24.(1).

A Critical Incident Report was submitted to the Ministry which alleged staff to resident neglect. There was a 40 hour gap between the incident and submission to the Ministry.

An interview with the Administrator confirmed that it was the expectation of the home that any alleged or suspected incidents of neglect of a resident was to be immediately reported to the Director, that in the case of the Critical Incident Report cited this did not occur and should have.

The scope of this issue was isolated to the resident involved in the Critical Incident Report that was not reported immediately to the Director. There was a previous on-going compliance order issued related to this. The severity was determined to be actual risk of harm to the health, safety and well-being of the resident. (620) [s. 24. (1)] (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 30th day of November, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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