Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 21, 2016	2016_463616_0004	001644-16	Resident Quality Inspection

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

JENNIFER KOSS (616), JULIE KUORIKOSKI (621), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 1-5, 8-12, 2016

Additional intakes completed during this inspection included: #033820-15, #033853-15 and #033854-15 related to follow up of past due compliance orders and Critical Incident (CI) logs:
#012942-15 related to a CI the home submitted regarding resident care not provided by staff as requested,
#013262-15 related to a CI the home submitted regarding the misappropriation of a resident's money,
#013291-15 related to a CI the home submitted regarding the misappropriation of a resident's money,
#013435-15 related to a CI the home submitted regarding a staff who did not respond to a resident' call bell,
#020158-15 related to a CI the home submitted regarding staff to resident abuse,
#023262-15 related to a CI the home submitted regarding improper treatment that resulted in harm or risk of harm to a resident,
#029054-15 related to a CI the home submitted regarding improper treatment that resulted in harm or risk of harm to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (AD/DOC), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aides, Recreation Therapist, Administrative Assistant, family members, and residents.

Observations were made of the home areas, meal services, and the provision of care and services to residents during the inspection. The home's policies and procedures, and resident health records were reviewed.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **8 VPC(s)**
- **2 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. 131. (4)	CO #005	2015_264609_0053	616
LTCHA, 2007 S.O. 2007, c.8 s. 15. (2)	CO #002	2015_264609_0053	617
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2015_264609_0053	616
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #006	2015_264609_0053	616
LTCHA, 2007 S.O. 2007, c.8 s. 31. (2)	CO #004	2015_264609_0053	621
O.Reg 79/10 s. 31. (3)	CO #002	2015_336620_0006	617

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).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A Critical Incident System (CIS) report was submitted by the home in June 2015, related to an incident that involved misuse/misappropriation of a resident's money that occurred in 2014.

The Administrator/Director of Care (AD/DOC) documented resident #022's report of missing money in progress notes as a late entry 12 days after the resident reported it to them.

During an interview with the AD/DOC on February 9, 2016, they stated they were unable to verify the resident's report of missing money. However, one of the actions planned by the home on the CIS report to correct the situation and prevent recurrence, was to implement an intervention to discourage any wandering residents from entering the resident's room. They stated to Inspector #616 that this intervention should have been included in the resident's care plan.

The resident's care plan in effect at the time of the incident, as well as the current plan, was reviewed. No reference was found to the planned intervention to deter wandering co-residents from entering their room.

The AD/DOC reviewed the care plans and confirmed to the Inspector that the above planned care had not been included in the resident's care plan and should have been. [s. 6. (1) (a)]

2. A CIS report was submitted by the home in June 2015, related to an incident that involved misuse/misappropriation of a resident’s money that occurred in 2014.

The Administrator/Director of Care documented resident #021’s report of missing money in progress notes as a late entry, 13 days after the incident. The progress note stated that staff were to ensure an intervention was implemented to deter wandering residents from entering the resident's room when they were not there.

During an interview with AD/DOC on February 9, 2016, they stated they were unable to verify the resident’s report of missing money. However, one of the actions planned by the home on the CIS report to correct the situation and prevent recurrence, was to ensure the implementation of a planned intervention to deter wandering residents from entering the resident's room when they were not there. They also stated this intervention should have been included in the resident’s care plan.

The resident's care plan in effect at the time of the incident in 2014, as well as the current plan, was reviewed for the intervention. No reference was found.

The AD/DOC reviewed the care plans and confirmed to the Inspector that the above planned care had not been included in the resident's care plan and should have been. [s. 6. (1) (a)]

3. A CIS report was submitted to the Director by the home in June 2015, related to an incident that involved allegations of abuse/neglect of resident #023. The report indicated that the resident reported that during the night, a staff member instructed them to void in their incontinent product, and the staff member would change them later. The CIS report documented that for future instances, staff would offer a bedpan at night, if unable to provide personal care required at that time.

The Inspector and the AD/DOC reviewed the care plan in effect at the time of the inspection and found no reference to the offer of the bedpan at night.

The AD/DOC stated this planned intervention related to continence care had not been included in the resident's care plan and should have been. [s. 6. (1) (a)]

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

During a meal service on February 9, 2016, Inspector #621 observed resident #019 had been provided two glasses of regular texture fluids.

A review of resident #019's diet as listed on the home's diet census, as well as the resident's care plan, did not identify what fluid consistency was to be provided to this resident. The home's diet census included other residents' fluid needs, such as regular versus regular modified fluids.

During an interview with PSW #101, they stated that they offered the resident #019 regular texture fluids and that this information could be found by staff in the resident's care plan, or the diet census report that was updated and maintained by the home's Registered Dietitian (RD).

During a review of resident #019's diet information located on the diet census, and resident care plan, RN #108 and RPN #107 confirmed that there was no documentation to identify the required fluid consistency for resident #019. Consequently, the written plan of care did not provide clear direction to staff and others who provide direct care to residents as to the appropriate fluid consistency required for resident #019. [s. 6. (1) (c)]

5. During two previous inspections, #2015_264609_0053 and #2015_331595_0003, Compliance Orders were issued for s.6.(1) related to resident #031's interventions in their plan of care that did not provide clear direction.

On three occasions in February 2016, Inspector #621 observed resident #031 outside of the home, alone and unattended.

During an interview with RN #108 on February 9, 2016, they stated that resident #031 was permitted to go outside alone, however as part of their plan of care, staff were to

complete hourly checks on the resident. This included staff monitoring when the resident was out of the building.

During a review of the most current care plan for resident #031, Inspector #621 noted the interventions included hourly checks, however, in a different section of the care plan, the intervention noted that staff were to complete resident checks every 30 minutes.

During an interview with RN #108, they stated that the details of resident #031’s care plan regarding timing of resident checks by staff was not clear and that it should have been. [s. 6. (1) (c)]

6. Resident #035 had a physician's order for altered skin integrity treatment in their health record. However, the resident’s current Pressure Ulcer/Wound Assessment Record provided staff different wound care instructions than the physician's order.

The Inspector reviewed the physician's orders in the resident's health record over a two month period and there was no order change for their altered skin integrity treatment.

In an interview with RN #115 and RPN #106, they both stated a physician's order should have been obtained to change the resident's altered skin integrity treatment and there was not clear direction related to this care. [s. 6. (1) (c)]

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

The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Quarterly Review, indicated that resident #035 had altered skin integrity.

The care plan available at the nursing station on the unit, noted a nutrition intervention related to the altered skin. It indicated that the resident was to have received a nutrition supplement at specific times. The resident's Medication Administration Record (MAR) was also reviewed and indicated the nutrition supplement at the same specified times.

Inspector #616 reviewed an order by the RD to give the nutrition supplement at increased times. The rationale for order was altered skin integrity "not improving".

During an interview with RN #115 and RPN #106, regarding the above RD order, they verified the order had not been processed and the resident had not received the nutrition

supplement as specified in their plan of care. [s. 6. (7)]

8. A review by Inspector #621 of resident #032’s care plan, under the Nutrition Status section, identified that this resident required a specific modified fluid texture.

During a meal service in February 2016, Inspector #621 observed PSW #121 pour a glass of pre-modified juice and provided it to resident #032. When Inspector #621 asked PSW #121 what fluid texture the resident required, they reported a different fluid texture than what was indicated in the care plan, and confirmed to this Inspector and the home's Recreation Therapist that they had provided this different fluid texture to the resident.

During an interview with the Recreation Therapist and RPN #106, they confirmed with Inspector #621 that the diet census report, and care plan for resident #032 both indicated that this resident required specific modified texture fluids and what was provided by PSW #121 was not consistent with this resident's plan of care. [s. 6. (7)]

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

During an interview with resident #030, they reported to Inspector #621, that they were no longer able to complete a component of their personal care. They stated they preferred and required assistance from staff for this particular activity.

Inspector #621 reviewed resident #030’s most recent care plan where it provided staff with different care instructions for this activity.

During an interview with RPN #106, they verified that resident #030’s care plan had not been updated to reflect this resident's current care needs and that it should have been. [s. 6. (10) (b)]

10. During an interview with resident #039, it was reported to Inspector #616 that this resident preferred that staff assisted them with a component of their personal care, at a specific time of day.

A review of resident #039’s most current care plan, indicated inconsistent information related to their current health needs and that staff were to complete this component of care at a different time than the resident's stated preference.

During an interview with RPN #106, they verified to Inspector #621 that this resident's care plan had not been updated and consequently, resident #039's plan of care was not consistent with their current care needs. [s. 6. (10) (b)]

11. During an interview with resident #035, they reported to Inspector #621 that they no longer were able to complete a component of their personal care, and required assistance from staff.

During an interview with PSW #100, they stated that resident #035 previously completed this component of their own care, however the resident required staff assistance.

Inspector #621 reviewed resident #035's current care plan and it identified that this resident could still complete this care when set up, and staff were to encourage resident to complete this activity.

During an interview with RPN #108, they verified to the inspector that this resident's care plan had not been updated specifically relating to resident #035's current care needs and should have been. [s. 6. (10) (b)]

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 #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Inspector #617 reviewed the staffing plan submitted by the AD/DOC, which indicated that part of the staffing mix for the home was a Registered Nurse (RN) was to be on duty and present in the building at all times. The RN shifts were 12 hour day (D) and night (N) shifts.

A review of the St. Joseph Manor Elliot Lake Policy, titled "Written Staffing /Contingency Plan-#NUR Vll-90" last revised December 2015, indicated that when an RN vacancy occurred, RN coverage on the night shift was a priority. The DOC during day shift will act as charge nurse in an emergency and an extra Registered Practical Nurse (RPN) will be assigned. The duties of the extra RPN in charge were defined in the Charge Nurse/Extra RPN task binder located on the second floor nursing station.

A review of the nursing schedule sign in sheets dated January 1, 2016, to February 5, 2016, indicated that there was no RN present for eight occasions of the 35 day period. Of those eight occasions when there was no RN present, the contingency plan to have a third RPN was not followed on three of those occasions.

On February 9, 2016, Inspector #617 interviewed the AD/DOC, who confirmed that the home did not have an RN on duty on eight occasions between January and February, 2016. The AD/DOC confirmed that the RN shortages were related to schedule vacancies, not emergencies. [s. 8. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Weight Recording and Monitoring Policy and Procedure was in compliance with and was implemented in accordance with all applicable requirements under the Act; and was complied with.

A review of the home's weight records over a six month period for resident's #035, #037 and #038, identified significant weight changes as follows:

-resident #035 had a recorded weight change of 17.30 per cent over a three month period
-resident #037 had a recorded weight change of 18.04 per cent over a one month period, as well as a 10.25 per cent weight change over a three month period
-resident #038 had a recorded weight change of 14.22 per cent over a one month period.

A review of the home's policy titled "Weight Recording & Monitoring - NUM III-43", last revised May 2006, identified that the process for recording and monitoring weights included:
a) Weight monitoring on a monthly basis using Med-e-care software
b) Residents with a significant unplanned weight change of 5 per cent or more over one month; 7.5 per cent over three months or 10 per cent or more over six months required further investigation using a multidisciplinary approach; and
c) Registered staff would communicate names of residents with unexplained weight loss or gain to the Registered Dietitian (RD).

During an interview on February 11, 2016, with RN #115 and RPN #106, they reported that resident weights were completed by PSW staff during bath care by the seventh day of each month. Either the RPN or RN would then enter these weights on the weight

record for each resident in Med-e-care. They also stated that the RPN or RN were to forward a paper referral form through dietary services to the RD for follow up of significant changes in nutrition status, including weight changes.

During an interview on February 11, 2016, Inspector #621 interviewed RN #115, RPN #106 and RPN #122 regarding the monthly weight reports for resident #035, #037 and #038. They confirmed that:

-resident #035 had a significant weight change of 17.30 per cent over a three month period
-resident #037 had a recorded weight change of 18.04 per cent over a one month period, and a 10.25 per cent weight change over a three month period
-resident #038 had a recorded weight change of 14.22 per cent over a one month period.

RN #115, RPN #106 and RPN #122 also reported the documentation process for generating referrals to the RD for follow up of significant weight changes had not been followed and that no referrals had been sent to the RD, and should have been.

During an interview on February 11, 2016, a member of the multidisciplinary team reported to Inspector #621 that a multidisciplinary referral form had not been completed regarding the significant weight changes for resident's #035, #037 and #038. They verified that monitoring of monthly weights for all residents, and referrals to communicate weight changes between the multidisciplinary team as per policy was not a consistent practice in the home. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place the Weight Recording and Monitoring Policy and Procedure, the licensee is required to ensure that the policy and procedure, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #4: 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.

A CIS report was submitted to the Director by the home in October 2015, related to an allegation of neglect of resident #019 by PSW #102. Staff had reported to the AD/DOC that they found resident #019 left sitting alone in the dining room, unattended for eight hours.

The Long Term "Care Homes Act Ontario Regulation 79/10 s. 5, defined "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A review of the home's internal investigation of the allegation of neglect was verified and PSW #102 resigned after the investigation was completed.

A review of St. Joseph's Manor, Elliot Lake policy titled "Zero Tolerance of Abuse and Neglect-#NUM Vll-7" last revised March 2015, indicated that this policy will be reviewed with each new employee during orientation and annually thereafter. The staff training and education will include policy and procedures for Zero Tolerance of Abuse and Neglect, Mandatory Reporting, and Whistle blowing protection against retaliation.

A review of PSW #102's personnel file indicated a hire date of 2015, and a resignation date approximately two months later. The training records for Zero Tolerance of Abuse and Neglect, Mandatory Reporting, and Whistle blowing protection were missing from PSW #102's personnel file.

On February 10, 2016, during an interview with the AD/DOC, they confirmed that PSW #102 had not been trained in the abuse policy, and that the home failed to protect resident #019 from neglect. [s. 19. (1)]

2. A CIS report was submitted to the Director in June 2015, regarding alleged emotional abuse of resident #018 by PSW #100.

A review of the home's investigation notes indicated that PSW #100 ignored several verbal requests by resident #018 for help and did not respond to the call bell which rang for eleven minutes. At that time resident #018 sat in the doorway of their room and observed PSW #100 in the hallway assisting other residents. Another staff member responded to the call bell and assisted resident #018. The home's internal investigation confirmed that PSW #100 was assigned to resident #018's care on the date of the incident. The allegations of emotional abuse were verified during the home's internal investigation 14 days later, resulting in disciplinary action of PSW #100.

The Long Term Care Homes Act Ontario Regulation 79/10 s. 5, defined "emotional abuse" as any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that were performed by anyone other than a resident.

A review of the personnel file for PSW #100 who was involved in the incident with resident #018, cited six prior incidents that resulted in discipline and confirmed violation of residents' rights and resident abuse over the course of their employment at the home.

During an interview with the AD/DOC, they confirmed that the home had completed their investigation and verified 14 days after the incident occurred that PSW #100 did emotionally abuse resident #018.

The Inspector reviewed the nursing schedule reports from the date of the incident over the following 14 days to investigation close, which revealed that PSW #100 was transferred to work on a different care unit three days after the incident.

During an interview with a member of the multidisciplinary team, they reported to the Inspector that PSW #100 did not work any shifts between the date of the incident to the date they were transferred to the other care unit, three days later.

Inspector #617 reviewed the St. Joseph's Manor Elliot Lake policy titled "Zero Tolerance

of Abuse and Neglect-#NUM Vll-7" last revised March 2015, which indicated that the home:
-was committed to a zero tolerance of abuse or neglect of its residents,
-defined abuse in relation to a resident, as any physical, sexual, emotional or financial abuse,
-Administrator/Director of Care was to ensure that the alleged perpetrator shall not have any unnecessary contact with the resident during the abuse investigation.

During an interview with the AD/DOC, they confirmed that it was the expectation of the home, that the policy on Zero Tolerance for Abuse and Neglect of residents was complied with by staff, and that the home failed to protect resident #018 from emotional abuse. [s. 19. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's written policy that was in place to promote zero tolerance of abuse and neglect of residents was complied with.

A CIS report was submitted to the Director in August 2015, regarding neglect of resident #020 by RPN #103. A review of the home's investigation notes indicated that resident #020 had submitted a verbal complaint to AD/DOC which indicated that on a particular day, after an interaction with RPN #103, resident #020 required treatment by the Emergency Department, where they returned to the home the next day.

A review of the St. Joseph's Manor, Elliot Lake titled "Zero Tolerance of Abuse and Neglect- policy #NUM Vll-7" last updated March 2015, indicated the following regarding staff training:

-Residents' Bill of Rights and the policy on Zero Tolerance of Abuse and Neglect will be reviewed with each new employee during orientation and annually thereafter
-staff training and education will include policy and procedures for Zero Tolerance of Abuse and Neglect, Reporting and Whistle blowing protection against retaliation.

A review of RPN #103's personnel file revealed missing training records for RPN #103's orientation and annual re-training in the home's policies for "Zero Tolerance of Abuse", "Mandatory Reporting", and "Whistle Blowing".

On February 10, 2016, during an interview with AD/DOC, they clarified that RPN #103 was not trained in the home's abuse policies when the incident of neglect occurred with resident #020 and should have been as an expectation of the home's policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

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 the person, who had reasonable grounds to suspect that abuse of a resident by anyone had occurred, immediately reported the information upon which it was based to the Director.

A CIS report was submitted to the Director in July 2015, regarding emotional abuse of resident #017 by PSW #101, however the incident occurred six days earlier than the CIS was reported to the Director.

In a previous inspection report #2015_264609_0053, Compliance Order #006 was issued to the home on November 30, 2015, with a compliance due date of December 31, 2015. This incident occurred and the CIS had been submitted by the home prior to the compliance date.

Progress notes by registered staff in the home's investigation record indicated that resident #017 reported that PSW #101 had been emotionally abusive towards the resident on three separate occasions with resident #017 during the resident's request for assistance with an activity of daily living, personal care, and a meal.

A review of the St. Joseph's Manor Elliot Lake titled "Zero Tolerance of Abuse and Neglect- policy #NUM Vll-7" last revised March 2015, indicated that all staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone and neglect of a resident by a staff member of the home. The report was to be submitted to the Ministry of Health and Long Term Care immediately upon becoming aware the incident.

On February 10, 2016, the Inspector interviewed the AD/DOC, who verified that the home was aware of the suspected emotional abuse incident when resident #017 reported to the registered staff and did not report it to the Director until six days later. [s. 24. (1)]

2. A CIS report was submitted to the Director in June 2015, regarding emotional abuse of resident #018 by PSW #100, however the incident occurred four days earlier than when the CIS was reported to the Director.

A review of the home's investigation notes indicated that resident #018 submitted a complaint to the AD/DOC on the date of incident. They claimed that PSW #100 ignored several verbal requests for help and let the call bell ring for eleven minutes. Resident #018 sat in the doorway to their room and observed PSW #100 in the hallway assisting other residents. Another staff member responded to the call bell and assisted resident #018. The investigation notes indicated that PSW #100 was assigned to resident #018's care.

A review of the St. Joseph's Manor Elliot Lake policy titled "Zero Tolerance of Abuse and Neglect-#NUM Vll-7" last revised March 2015, indicated that all staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone and neglect of a resident by a staff member of the home. The report was to be submitted to the Ministry of Health and Long Term Care immediately upon becoming aware the incident.

On February 10, 2016, the Inspector interviewed the AD/DOC, who confirmed that the home had been aware of the suspected emotional abuse incident when resident #018 submitted the complaint to them and did not report to the Director until four days later. [s. 24. (1)]

3. A CIS report was submitted to the Director in August 2015, regarding neglect of resident #020 by RPN #103. However, the incident occurred 19 days earlier than when the CIS was reported to the Director.

A review of the home's investigation notes indicated that resident #020 had submitted a verbal complaint to AD/DOC which indicated that on a particular day, after an interaction with RPN #103, resident #020 required treatment by the Emergency Department, where they returned to the home the next day.

A review of the St. Joseph's Manor Elliot Lake policy titled "Zero Tolerance of Abuse and Neglect-#NUM Vll-7" last updated March 2015 indicated that all staff must report all alleged, suspected or witnessed incidents of abuse of a resident by anyone and neglect of a resident by a staff member of the home. The report was to be submitted to the Ministry of Health and Long Term Care immediately upon becoming aware the incident.

On February 10, 2016, the Inspector interviewed the AD/DOC, who confirmed that the home had been aware of the suspected neglect on August 10, 2015, when #020 reported their complaint to the AD/DOC, and submitted the CIS report to the Director late. [s. 24. (1)]

Additional Required Actions:

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

WN #7: 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 a resident who exhibited 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, if clinically indicated.

Inspector #616 reviewed the health record for resident #035 related to skin and wound assessments and documentation over a 72 day period. The resident was assessed to have had an area of altered skin integrity with measurements of the area included.

There was a gap of 14 days between assessments in a one month period, where the area was assessed as worsened, without the size of the altered skin measured.

The assessment documentation became unclear if reassessments were completed weekly as the next assessment was undated. This was followed by an assessment dated 17 days after the last dated assessment.

The assessments over that 17 day period, made reference to, and identified, two areas of altered skin integrity. It was unclear by the documentation which of the two areas were assessed, as only one measurement was indicated.

The home's policy titled "Skin and Wound Care Program-NUM VI-105", last revised February 2015, indicated the Pressure Ulcer/Wound Assessment Record was to be completed weekly and included, but not limited to, the size (circumference and depth) of the wound.

During an interview with the AD/DOC, regarding the 14 day gap in assessments, they stated the weekly wound assessment between these dates had not occurred. The assessment documentation over the 17 days was also reviewed. They were unable to verify whether the weekly assessment had occurred during this time, or which of the two altered skin areas had been assessed. [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 that 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, (iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the nutrition care and hydration programs included, weight on admission and monthly thereafter.

During Stage 1 of the Resident Quality Inspection, Inspectors #621, #617, and #616 noted that 15 of 40 residents, or 37.5 per cent, were missing monthly weights.

A review of the weight history for each of the 15 residents over a 13 month period revealed a range of missing weight measurements from two to eight months.

The home's policy titled "Weight Recording & Monitoring policy-Num III-43", last revised May 2008, stated that resident weight were to be measured and recorded on admission and monthly thereafter.

During an interview with RPN #106 and the AD/DOC, they both stated the home's expectation was that weights were measured by PSW staff and recorded by registered staff monthly. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that the nutrition care and hydration programs included, height upon admission and annually thereafter.

Upon review of resident health records, Inspector #621 observed that an annual height was not recorded for the following residents:

-resident #030, last height taken December 2014
-resident #035, last height taken April 2014
-resident #034, last height taken April 2014
-resident #039, last height taken January 2015
-resident #040, last height taken November 2014
-resident #024, last height taken January 2015
-resident #019, last height taken January 2015

During an interview on February 2, 2016, with RPNS #107 and #104, they reported to Inspector #621 that an admission height was required, but were unsure of how often heights were to be taken thereafter.

A review of the home's policy DTRLTC-PM B3-24 titled "Resident Care & Services - Resident Assessment - 4", last revised March 2015, identified that each resident's height will be recorded on admission and annually.

During an interview on February 9, 2016, with RPN #107, they confirmed that the last recorded height for resident's #030, #035, #034, #039, #040, #024 and #019 were not

remeasured in the past year as per home's policy and legislative requirements. [s. 68. (2) (e) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that every licensee of a long-term care home shall ensure that the nutrition care and hydration programs include, a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(b) includes menus for regular, therapeutic and texture modified diets for both meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle included menus for regular, therapeutic and texture modified diets for meals and snacks.

During a review of the planned menu, as posted in the home's dining room areas, it was identified by Inspector #621 that there were no menu items identified for snacks.

During an interview on February 1, 2016, Dietary Aide #113 reported that dietary staff had access to a snack menu posted in a closed cupboard in the servery. On review of this snack menu it was last updated February 8, 2013. Dietary Aide #113 confirmed that this snack menu was outdated, and verified that there was no current snack menu posted in the resident home areas that unit staff or residents could reference.

During an interview with the RD on February 5, 2016, they identified that a snack menu for regular diets was available, but this had not been developed as part of the cycle menu, was not posted with the snack carts on the units, and was not posted for the residents reference. Additionally, they reported that snack menus had not been developed for the therapeutic or texture modified diets. [s. 71. (1) (b)]

2. The licensee has failed to ensure that the menu cycle included alternate beverage choices at meals and snacks.

During the course of this inspection, a review of the planned menu as posted in the home's dining rooms did not provide information on beverage choices for lunch and dinner meals. Similarly, the day-at-a-glance menu as hand-written on the white board in the dining rooms was observed by Inspector #621 also did not provide information on beverage choices for breakfast, lunch or dinner meals.

During an interview on February 10, 2016, Dietary Aide #112 reported to Inspector #621 that the planned menu posted in the dining room bulletin board was the home's current menu, and that it did not identify main, or alternate beverage choices for lunch or dinner.

During an interview with the RD on February 5, 2016, they confirmed that the planned menu did not provide information on beverage choices for the lunch or dinner meals. Additionally, they identified that the home had not yet developed a planned menu for texture modified fluid options. [s. 71. (1) (d)]

3. The licensee has failed to ensure that the home's menu was reviewed by the Residents' Council.

During an interview with the Resident Council President on February 4, 2016, resident #017 identified that during the past year there had not been a copy of the menu cycle

brought forward for resident's review to the Residents' Council meetings.

Inspector #621 reviewed a copy of the March 2015 menu review completed by the RD which identified in this report that St. Joseph's Manor was to ensure resident input into menu planning process, and confirm this occurred through Resident Council minutes documentation. However, there was no information in this team member's comments section of the report that this had been accomplished.

During a meeting with the RD on February 9, 2016, they confirmed that a copy of the planned menu cycle did not come to Residents' Council for review with residents prior to the planned menu being implemented in the home. [s. 71. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that every licensee of a long-term care home shall ensure that the home's menu cycle, (d) includes alternative beverage choices at meals and snacks, to be implemented voluntarily.

WN #10: 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

On February 4, 2015, the Resident Council President, resident #017 stated to Inspector #621 that there is no review of meal and snack times for the home at Residents' Council meetings.

A review of the Home's Dietary Policy and Procedure titled "Meal Service - Dining and Snack Service", last revised March 2015, identified that as per 73. (1) 2., that every licensee of a long term care home shall ensure that the home has a dining and snack service which completes a review, subject to compliance with subsection 71(6), of meal and snack times by the Residents' Council.

During an interview with the RD on February 5, 2016, they confirmed that neither they nor the Food Services Supervisor have completed a review of the meal and snack times with Residents' Council. [s. 73. (1) 2.]

2. The licensee has failed to ensure that staff assisting residents are aware of the residents' diets, special needs and preferences.

On February 1, 2, 3, 4 and 5, 2016, Inspector #621 observed that the insulated snack carts carried no resident diet information to specify resident diets, reported food sensitivities, or resident diet preferences.

During an interview with Inspector #621 on February 1, 2016, PSW #117 reported that staff do not have information about resident diets, special diet needs or preferences to refer to when delivering snacks to residents.

During an interview with the RD on February 5, 2016, they confirmed that resident diet information provided for snack service did not include details concerning resident food allergies or diet preferences. They identified that they had one resident with a food allergy as part of their diet restrictions and current diet information provided to staff for reference would not have included this information. They confirmed this was a risk to resident health and well-being. [s. 73. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that 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: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items.

On February 1, 2016, during a tour of the home Inspector #617 observed the following un-labelled personal items stored in a tub room:
-six used deodorant sticks
-one Conair electric razor
-two electric razors

On February 1, 2016, during a tour of the home Inspector #617 observed the following un-labelled personal items stored in a tub room:
-five electric razors
-three brushes with hair
-two combs with dandruff

A review of St.Joseph's Manor policy titled “Personal Hygiene Supplies and Equipment - #lll-75” last revised May 2008, indicated that it is the responsibility of the nursing staff to maintain proper care and cleaning of electric shavers and after using the personal hygiene supplies on resident, staff will store them in containers provided on each unit.

Inspector #617 interviewed PSW #109, who confirmed that the residents' electric shavers and their own personal products should have been labelled to identify which resident they belonged to. [s. 37. (1) (a)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that copies of the inspection reports from the past two years for the long-term care home were posted in the home in a conspicuous and easily accessible location.

On February 1, 2016, Inspector #617 conducted an initial tour of the home and observed that the public copies of inspection reports were found at the entrance to the home in a blue portfolio labelled "MOH Reports" in the wall mounted display beside the bulletin board.

Inspector #617 reviewed the reports posted and compared that with the reports issued to the home over the past 2 years and found that the following reports were missing from the posting:
2015_336620_0007 Critical Incident
2014_332575_0015 Critical Incident
2014_336580_0017 Complaint
2014_336580_0018 Follow Up
2014_246196_0001 Resident Quality Inspection.

On February 03, 2016, both Inspector #617 and the AD/DOC attended the bulletin board and reviewed the posted reports in the blue portfolio. At that time the AD/DOC confirmed to the inspector that there were four reports from 2014 and one report from 2015, that were not posted at the time of inspection. [s. 79. (3) (k)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs.

On February 4, 2016, Inspector #617 conducted a review of a medication storage room and found several medications that were expired, which included:
-three bottles of Swiss Super B complex vitamin expiry date March 2015
-four bottles of Swiss Multivitamins expiry date December 2015
-one box of Rougier Glycerin suppositories (17 left in box) expiry date December 2014.

Inspector #617 reviewed the Rexall Specialty Pharmacy policy titled "Discontinued/Expired Medications -#7.3" last revised January 17, 2011, which indicated that medications that have expired, shall be removed from the medication storage area immediately to eliminate the risk of administering an expired medication to the resident.

On February 4, 2016, Inspector #617 interviewed the AD/DOC, who confirmed that the medication was expired and should have been removed by the pharmacist when they audited the storage room. [s. 129. (1) (a)]

Issued on this 18th day of April, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER KOSS (616), JULIE KUORIKOSKI (621), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2016_463616_0004
Log No. / Registre no:	001644-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 21, 2016
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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_264609_0053, 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 must prepare, submit and implement a plan for achieving compliance with the LTCHA, 2007, S.O., c. 8, s. 6 (1) that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The plan is to include steps the licensee will take to:

1) ensure the plan of care for resident #031, and all other residents who exit the home independently without supervision, provides clear directions to staff related to monitoring the safety of the residents.

2) ensure plan of care related to the fluid consistency for resident #019, wound care for resident #035, and all other residents, provides clear directions to staff.

3) implement strategies that will ensure that the written plan of care for all residents are reviewed and updated to set out clear directions of the residents' planned care to staff.

4) train the staff who develop the residents' written plan of care to ensure clear directions are identified for the direct care providers.

5) train the direct care providers related to plans of care.

This compliance plan is due to be submitted by March 28, 2016 to Jennifer Koss, Nursing Inspector #616 via email at jennifer.koss@ontario.ca. Implementation and full compliance is to be achieved by April 11, 2016.

Grounds / Motifs :

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

On three occasions in February 2016, Inspector #621 observed resident #031 outside of the home, alone and unattended.

During an interview with RN #108 on February 9, 2016, they stated that resident #031 was permitted to go outside alone, however as part of their plan of care, staff were to complete hourly checks on the resident. This included staff monitoring when the resident was out of the building.

During a review of the most current care plan for resident #031, Inspector #621 noted the interventions included hourly checks, however, in a different section of the care plan, the intervention noted that staff were to complete resident checks every 30 minutes.

During an interview with RN #108, they stated that the details of resident #031's care plan regarding timing of resident checks by staff was not clear and that it should have been.
(621)

2. Resident #035 had a physician's order for altered skin integrity treatment in their health record. However, the resident's current Pressure Ulcer/Wound Assessment Record provided staff different wound care instructions than the physician's order.

The Inspector reviewed the physician's orders in the resident's health record over a two month period and there was no order change for their altered skin integrity treatment.

In an interview with RN #115 and RPN #106, they both stated a physician's order should have been obtained to change the resident's altered skin integrity treatment and there was not clear direction related to this care. (616)

3. During a meal service on February 9, 2016, Inspector #621 observed resident #019 had been provided two glasses of regular texture fluids.

A review of resident #019's diet as listed on the home's diet census, as well as the resident's care plan, did not identify what fluid consistency was to be provided to this resident. The home's diet census included other residents' fluid needs, such as regular versus regular modified fluids.

During an interview with PSW #101, they stated that they offered the resident #019 regular texture fluids and that this information could be found by staff in the resident's care plan, or the diet census report that was updated and maintained by the home's Registered Dietitian.

During a review of resident #019's diet information located on the diet census, and resident care plan, RN #108 and RPN #107 confirmed that there was no

documentation to identify the required fluid consistency for resident #019. Consequently, the written plan of care did not provide clear direction to staff and others who provide direct care to residents as to the appropriate fluid consistency required for resident #019.

The scope of this issue is isolated, the severity is determined to be of minimum risk, as unclear directions related to resident care has the potential to negatively affect the health, safety and well-being of the residents within the home.

Previous non-compliance specific to LTCHA 2007, S.O.2007, c.8, s. 6 was identified during the following inspections:
-A Director's Referral and two previous compliance orders (CO) were issued in Follow Up inspection report #2015_264609_0053, served to the home on November 30, 2015, and Resident Quality inspection report #2015_331595_0003, served to the home on May 29, 2015.
-A voluntary plan of correction (VPC) was issued in Critical Incident System inspection report ##2014_332575_0015 in September 2014. (621)

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_336620_0006, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is required to prepare, submit and implement a plan for achieving compliance under s. 8 (3) of the LTCHA.

This plan is to include:

1) strategies for recruitment and retention for the employment of registered nurses to meet the legislative requirements of 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.

This compliance plan is due to be submitted by March 28, 2016, to Jennifer Koss, Nursing Inspector #616 via email at jennifer.koss@ontario.ca. Implementation and full compliance is to be achieved by April 11, 2016.

Grounds / Motifs :

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

Inspector #617 reviewed the staffing plan submitted by the AD/DOC, which indicated that a Registered Nurse (RN) is on duty and present in the building at all times. The RN shifts were 12 hour day (D) and night (N) shifts.

A review of the St. Joseph Manor, Elliot Lake Policy #NUR Vll-90, titled "Written Staffing Plan/Pattern/Contingency Plan" last updated December 2015, indicated that when an RN vacancy occurred, coverage on the night shift with an RN is priority. The DOC during day shift will act as charge nurse in emergency and extra Registered Practical Nurse (RPN) will be assigned. The duties of the extra RPN in charge were defined in the Charge Nurse/Extra RPN task binder located on the second floor nursing station. An interview with the AD/DOC confirmed that the expectation of the extra RPN in charge would be to fulfill the roles and tasks defined in the Charge Nurse/Extra RPN task binder.

A review of the nursing schedule sign in sheets dated January 1, 2016 to February 5, 2016, with verification from the AD/DOC, indicated that there was no RN present for eight occasions of the 35 day period. Of those eight occasions when there was no RN present, the contingency plan to have a third RPN was not followed on three of those occasions.

On February 9, 2016, during an interview with the AD/DOC, they confirmed that the RN shortages for January and February 2016, were related to schedule vacancies, not emergencies.

The scope is isolated, with on-going non-compliance issued in Complaint inspection report #2015_336620_0006, where a CO was served to the home in December 2015, and a previous VPC was issued in Resident Quality Inspection #2014_256196_0001. The severity is determined to be of minimal harm/risk or potential for actual harm/risk as not having at least one RN on duty and present in the home at all times has the potential to negatively affect the health, safety and well-being of the residents within the home. (617)

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 : Apr 11, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 21st day of March, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Koss

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