Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 1, 2018 | 2018_615638_0002 | 000633-18 | 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**

RYAN GOODMURPHY (638), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): January 22-26, 29-31 and February 1-2, 2018.**

**The following intakes were inspected during this Resident Quality Inspection;**
**-One log was related to CO #001 from Inspection report #2017_638609_0004, s. 24 (1) of the Long-Term Care Homes Act (LTCHA), 2007, specific to reporting certain matters to the Director;**
**-One log was related to CO #002 from Inspection report #2017_638609_0004, s. 8 (1) of the Ontario Regulation (O. Reg.) 79/10, specific to the home's Infection**

**Prevention and Control (IPAC) program;**
**-One log was related to CO #003 from Inspection report #2017_638609_0004, s. 23 (1) of the LTCHA, 2007, specific to immediate investigations;**
**-One log was related to CO #004 from Inspection report #2017_638609_0004, s. 20 (1) of the LTCHA, 2007, specific to the home's policy of zero tolerance of abuse and neglect;**
**-One log was related to CO #005 from Inspection report #2017_638609_0004, s. 19 (1) of the LTCHA, 2007, specific to the home's duty to protect residents from abuse and neglect;**
**-One log was an anonymous complaint submitted to the Director which was related to staffing concerns;**
**-One log was a complaint submitted to the Director which was related to responsive behaviours, the home's call bell system, continence care, laundry services and allegations of improper care;**
**-One log was a complaint submitted to the Director which was related to alleged staff to resident verbal abuse;**
**-One log was a complaint submitted to the Director which was related to safety concerns within the home;**
**-One log was a complaint submitted to the Director which was related to alleged staff to resident abuse, improper care, fall management and staffing concerns;**
**-One log was a complaint submitted to the Director which was related to responsive behaviours, continence care, skin an wound and notification of changes in resident status;**
**-One log was related to an incident of alleged staff to resident physical abuse;**
**-One log was related to an unwitnessed fall which resulted in an injury; and**
**-One log was related to an incident of resident to resident sexual abuse.**

**During the course of the inspection, the inspector(s) spoke with the Adminstrator/Director of Care (DOC), Maintenance Manager, Food Service Manager (FSM), Registered Dietitian (RD), Food Service Supervisor, Resident Assessment Instrument (RAI) Coordinator, Activities Coordinator, Registered Nurses (RN), Registered Practical Nuses (RPN), Personal Support Workers (PSW), Dietary Aid (DA), Housekeeping Aid, Physiotherapy Aid, Administrative Assistant, residents and their family members.**

**The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant staff personnel files, internal investigation notes, licensee policies, procedures, programs, relevant**

**training and resident health care records.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Reporting and Complaints**
**Residents' Council**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**

**During the course of this inspection, Non-Compliances were issued.**
- **15 WN(s)**
- **8 VPC(s)**
- **2 CO(s)**
- **0 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #005 | 2017_638609_0004 | 638 |
| LTCHA, 2007 S.O. 2007, c.8 s. 20. (1) | CO #004 | 2017_638609_0004 | 638 |
| LTCHA, 2007 S.O. 2007, c.8 s. 23. (1) | CO #003 | 2017_638609_0004 | 638 |
| LTCHA, 2007 S.O. 2007, c.8 s. 24. (1) | CO #001 | 2017_638609_0004 | 638 |
| O.Reg 79/10 s. 8. (1) | CO #002 | 2017_638609_0004 | 687 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,**
**(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).**
**(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).**

**s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #679 reviewed a complaint submitted to the Director related to staffing issues in the home. The complaint alleged that the home was often short staffed, resulting in residents having to wait a prolonged period of time for care. The complaint further identified that call bells were not being answered and that resident care was being jeopardized.

According to s. 8 (2) of the Long Term Care Homes Act (LTCHA), 2007, personal support services means services to assist with the activities of daily living, including personal hygiene services and includes supervision in carrying out those activities.

a) During an observation, Inspector #679 identified that resident #015's call bell was ringing for approximately 25 minutes. During another observation, Inspector #679 observed that resident #022's call bell had been ringing for approximately 26 minutes.

In an interview with Inspector #679, resident #015 identified that they were waiting for assistance with continence care.

During an interview with Inspector #679, resident #022 identified that they felt that the home was always short staffed and that they had to wait long periods of time for staff to assist them with their care needs.

b) Inspector #679 reviewed the staffing schedule over a 14 day period in January 2018. The Inspector identified eight dates the home was short at least one PSW and on four of those dates, the home worked short two PSWs.

Inspector #679 reviewed the "versus" call bell system record to identify resident call bell response times, when the home worked two PSWs short. Upon review, the Inspector identified one occasion that a resident call bell was active for one hour and four minutes. The Inspector noted that over a three day period in which the home was short staffed, there were approximately 64 occasions in which residents had to wait more than ten minutes for staff to respond to their call bell and approximately 36 of these calls were greater than 20 minute wait times.

In an interview with Inspector #679, PSW #108 indicated that when the home was short staffed, the residents had to wait up to ten minutes for their call bell to be answered, due to increased workload.

Inspector #679 reviewed the "versus" call bell system record with PSW #110. Upon review, the PSW stated that the frequently recorded wait times of 17 or 20 minutes was too long.

In an interview with Inspector #679, RPN #124 stated that an acceptable time for resident ’s to wait for a response when they rang their call bell, would be approximately five minutes.

In an interview with Inspector #679, the DOC/Administrator indicated that the wait time for a response when a call bell was initiated, should be less than five minutes. The DOC/Administrator stated, in some cases when staff were responding to other residents, the wait times may be longer. The DOC/Administrator identified that the wait times identified were concerning and acknowledged that the recorded times outlined in the "verus" report were excessive. [s. 8. (1) (b)]

2. The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care worked in that capacity, they were not considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

Inspector #679 reviewed a complaint submitted to the Director related to staffing

concerns. The complaint alleged that the home was often short staffed, which resulted in residents having to wait long periods of time for care. The complaint further identified that call bells were not being answered in a timely manner and that resident care was being jeopardized.

In an interview with Inspector #638, the DOC/Administrator identified that they were both the DOC and Administrator of the home. The home was identified as having a licensed capacity of 64 beds.

According to s. 212 (1) of the O. Reg. 79/10, the licensee was to ensure that the home's Administrator worked regularly in that position on site at the home at least 16 hours per week in a home with a licensed bed capacity of 64 beds or fewer.

According to s. 213 (1) of the O. Reg 79/10, the licensee was to ensure that the home's Director of Nursing and Personal Care worked regularly on site at the home at least 24 hours per week in a home with a licensed bed capacity of more than 39 but fewer than 65 beds.

Inspector #679 reviewed a document provided by the DOC/Administrator. The document outlined the number of days they worked as an RN in the home since they initiated their role as DOC/Administrator in June 2017. The document identified that they worked 344 hours in the capacity of a RN, while fulfilling their role as the DOC and the Administrator.

In an interview with Inspector #679, the DOC/Administrator identified that the home had issues with RN staffing. They indicated that they worked in the capacity of an RN for approximately 300 hours since being employed in the home (June 2017). The DOC/Administrator stated they had not been able to make up the hours that they spent working as an RN, while working in the capacity of a DOC/Administrator. [s. 8. (4)]

***Additional Required Actions:***

***CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

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

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

**Findings/Faits saillants :**

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

Resident #013 was identified during an observation by Inspector #638, as having a potential restraint.

Inspector #638 reviewed resident #013's care plan and identified under the "Restraint" foci that the resident had a restraint. The Inspector was unable to identify the type of restraint the resident required, nor when the restraint was supposed to be applied.

In an interview with Inspector #638, PSW #103 indicated that when a resident required a restraint, staff would be aware of this need by reviewing the resident's care plan or kardex, was in a specific location. The PSW stated that resident #013 required a specific restraint while up, for safety. The Inspector reviewed resident #013's care plan with the PSW who indicated that the restraint intervention was not clear as to the type of device that resident #013 required.

During an interview with Inspector #638, RPN #102 stated that staff access the resident's care plan for any interventions related to resident care, which included restraints. Upon reviewing resident #013's care plan, the RPN stated that the plan did not indicate what type of restraint the resident required and that this should be identified.

The home's policy titled "Care Plan Development & Monitoring - NUM III-10" last reviewed May 2008, indicated the strategies and intervention actions should be brief but specific enough to give direction and avoid any conflicting interpretation.

In an interview with Inspector #638, the DOC/Administrator indicated that the resident specific care plan should identify any resident specific restraints. The Inspector reviewed resident #013's care plan with the DOC/Administrator who indicated that the restraint intervention was not clear as to what type of restraint intervention the resident required and could have caused confusion. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complemented each other.

A complaint was submitted to the Director which indicated that they were concerned that resident #020 frequently went long periods of time without being bathed.

Inspector #638 reviewed resident #020's health care records and identified in their care plan that the resident's bath days were on two specific days each week, in the afternoon. The Inspector reviewed the residents' bath schedule list located in the PSW work binder, which indicated that the resident was scheduled for their baths on two specific days each

week, in the morning.

In an interview with Inspector #638, PSW #123 indicated that resident #020 went for their shower on two specific days each week, in the mornings as per the bathing list in the PSW binder.

During an interview with Inspector #638, PSW #103 indicated that the resident was bathed on two specific days each week, in the mornings. The PSW indicated that they would expect the resident's care plan to indicate the same bath times to avoid any confusion.

In an interview with Inspector #638, the DOC/Administrator indicated that resident #020's care plan should be updated to indicate the resident's current bath times to avoid confusion related to resident care routines. [s. 6. (4) (b)]

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

A complaint was submitted to the Director which alleged continence care concerns related to resident #020's bowel management interventions. The complaint alleged that the resident would frequently be found soiled, without their specific bowel management intervention applied.

On a specific date, resident #020 was observed by Inspector #638 with their specific bowel management intervention removed and a moderate amount of dried stool on the resident's pajamas and bedding. In an interview with the resident's family member, they indicated that they often found the resident in the mornings without their specific bowel management intervention applied and the resident soiled with stool.

Inspector #638 reviewed resident #020's care plan and identified under their bowel foci that the PSW would check to ensure that the resident's specific bowel management intervention was changed and fastened correctly, at least three times a shift and that staff were to ensure that the resident was wearing their specific intervention. The Inspector was unable to identify any location where these checks and changes were documented within the resident's health care records.

In an interview with Inspector #638, PSW #123 indicated that staff would check to ensure that the resident's specific bowel management intervention was applied properly

periodically through their shift, but they did not document this care anywhere as they would just check to ensure implementation.

During an interview with Inspector #638, PSW #122 stated that staff would check resident #020’s specific bowel management intervention a few times a shift to ensure that the resident did not remove the device. They indicated that they did not document these checks or changes when providing care to the resident and were unable to identify how they could demonstrate that the care was provided.

In an interview with Inspector #638, the DOC/Administrator indicated that resident #020 required frequent checks of their specific bowel management intervention, as they sometimes removed the device without notifying staff. The DOC/Administrator indicated that staff should check the device often to ensure that it was still applied, but there was no where to document these checks and it was difficult to identify when the resident was checked. The DOC/Administrator also indicated that there had been two occasions where resident #020’s family approached them to indicate that the resident did not have their specific bowel management intervention applied and it was unclear if or when the resident was last checked on these dates. [s. 6. (9) 1.]

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

A Critical Incident System (CIS) report was submitted to the Director related to an incident that caused an injury to resident #002, in which they were taken to hospital. The report outlined that resident #002 sustained a fall which resulted in a change in their health status.

Inspector #679 reviewed resident #002's electronic care plan, which outlined that direct care staff were to implement a specific intervention periodically, on a set schedule.

Inspector #679 observed the resident asleep in bed from 0905 hours to 0935 hours. The inspector did not observe any staff members implement the specific intervention as outlined within the resident's care plan.

In an interview with Inspector #679, PSW #106 indicated that resident #002 had a specific intervention for their fall management, which was implemented on a set schedule (contrary to the intervention identified in their care plan) and that the implementation of

this intervention was documented on a specific form.

In an interview with PSW #108, they indicated that the resident had a specific intervention to minimize their risk of falls and that this intervention was documented on a specific form according to a set schedule (contrary to the intervention identified in their care plan).

In an interview with PSW #113 they identified that the resident had a specific intervention implemented to minimize their fall risk and that the implementation of this intervention was documented on the form based on a set schedule (contrary to the intervention identified in their care plan).

RN #101 and Inspector #679 reviewed the current care plan for resident #002. RN #101 identified that the resident was supposed to have a specific intervention implemented while they were in bed to minimize their risk of falls.

In an interview with the DOC/Administrator they identified that the specific intervention was implemented after the resident sustained a fall. The DOC/Administrator identified that the resident's condition had since changed and the care plan should have been updated to reflect this change as they no longer required this specific intervention. [s. 6. (10) (b)]

5. A complaint was submitted to the Director which indicated that resident #002 was found with two areas of altered skin integrity on a specific date in May 2017, of an unknown origin.

Inspector #638 reviewed resident #020's health care records and identified in the resident's care plan under their "Skin Integrity" foci that the resident required an intervention related to skin integrity concerns. There was no other indication as to what type of device was required for the resident.

In an interview with the Inspector, PSW #122 indicated that direct care staff reviewed the residents' care plans for resident specific interventions. Upon reviewing resident #020's care plan, they indicated that they did not believe the resident had any specific intervention implemented related to skin integrity concerns.

During an interview with Inspector #638, RPN #102 indicated that direct care staff referred to the resident's care plan for interventions. Upon reviewing resident #020's care

plan with the RPN, they indicated that they were not certain what the intervention related to their skin integrity concerns were.

In an interview with Inspector #638, PSW #123 indicated that PSWs monitored residents for altered skin integrity during care and were responsible for implementing resident specific interventions. The Inspector reviewed resident #020's care plan with the PSW who indicated that the intervention related to their skin integrity concerns was not clear and that the resident did not have any specific devices that they were aware of.

Inspector #638 observed resident #020's room with PSW #123, who indicated that there was no specific intervention implemented related to the resident's skin integrity concerns and indicated that there were no other interventions being implemented at this time.

The home's policy titled "Care Plan Development & Monitoring - NUM III-10" last reviewed May 2008, indicated that changes in level of care warranted immediate changes in the resident's care plan.

In an interview with Inspector #638, the DOC/Administrator indicated that the resident's care plan should be updated whenever the resident's care needs changed. The Inspector reviewed resident #020's skin integrity intervention with the DOC/Administrator who indicated that the resident did not have any specific interventions at this time and the care plan should have been updated when it was no longer a relevant intervention. [s. 6. (10) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that 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 and ensure the resident is 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 is no longer necessary, to be implemented voluntarily.***

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**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 home's policy titled "Fall Prevention/Management Program" last reviewed in April 2016, was complied with.

A CIS report was submitted to the Director related to an incident that caused an injury to resident #002, for which they were taken to hospital. The CIS report outlined that the resident sustained a fall which resulted in a change in the resident's health status.

Inspector #679 reviewed resident #002's health care records. The resident's progress notes outlined that the resident had experienced ten falls over a 40 day period in 2017, two of which resulted in fractures.

The home's policy titled “Fall Prevention/Management Program” last reviewed in April 2016, outlined that if it was agreed to, staff were to arrange a care conference with the resident's Power of Attorney (POA) for residents who fall frequently as indicated by: Two falls in 72 hours, more than three falls in three months and more than five falls in six months. The policy further indicated that the interdisciplinary team was to conduct an interdisciplinary conference to determine the possible cause of falls and develop changes to prevent re-occurrence based on a quality improvement methodology.

Inspector #679 reviewed the health care records for resident #002 and was unable to locate any documentation to support that a care conference, or interdisciplinary meeting was held for the resident after their series of falls. Inspector #679 reviewed resident #002's health care records with RPN #104 and were unable to locate any indication that a care conference was held for this resident during the time in which they were experiencing frequent falls. The RPN stated that a care conference should have been held to discuss fall interventions.

In an interview with the DOC/Administrator, they indicated that if a care conference was held for a resident a notation would have been made in the progress notes. Inspector #679 reviewed the home's "Fall Prevention/Management Program" with the DOC/Administrator who stated that they did not believe a formal meeting was held for resident #002 after their series of falls. [s. 8. (1) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's "Fall Prevention/Management Program" is complied with, to be implemented voluntarily.***

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**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. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident was restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident was included in the resident’s plan of care.

Inspector #687 observed resident #007 on multiple occasions. The resident was observed with a specific restraint implemented.

The Inspector reviewed resident #007's health care records and was unable to identify any indication that the resident required the specific restraint, at any time.

In an interview with Inspector #687, PSW #105 stated that resident #007 had a specific restraint applied for safety as the resident was a high risk for falls and would attempt to get up without assistance.

During an interview with Inspector #687, RPN #114 stated that they were not aware of resident #007’s specific restraint. The RPN stated that there was no completed restraint assessment, family consent, physician order and the seat belt restraint was not identified in the resident’s care plan. The RPN indicated that resident #007 was also unable to release the specific restraint.

The home’s policy titled “Restraints: Minimizing Restraining of Residents and use of Restraints & PASD Program - NUM VII-55” last reviewed June 2017, indicated that authorized staff would establish resident focused goals including reduction of severity, frequency, duration, or elimination of the restraint.

In an interview with Inspector #687, the DOC/Administrator stated that all restraints required an assessment, consent from the family, physician's order and should be captured in the care plan prior to implementing a restraining device. [s. 31. (1)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident is restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

A complaint was submitted to the Director regarding resident #020's specific responsive behaviours towards certain care activities. The complaint alleged that the resident would go an extended period of time without a shower because of their specific responsive behaviours.

Inspector #638 reviewed resident #020's health care records and identified in the

electronic point of care (POC) "Observation/Flow Sheet Monitoring Form" multiple occasions where the resident did not receive their scheduled shower due to their specific responsive behaviours. The Inspector reviewed the bathing record over a three month period in 2017, and 2018. Upon review, the Inspector identified that the resident missed three of their nine scheduled baths in one month, two of their eight scheduled baths in the second month and three of their nine scheduled baths in the third month, due to their specific responsive behaviours. The resident missed eight of their 26 scheduled baths or 30 per cent of the time, due to their specific responsive behaviours.

In an interview with Inspector #638, PSW #123, #122 and #103 each indicated that whenever resident #020 was demonstrating specific responsive behaviours, they would leave the resident and re-approach shortly after. If that was unsuccessful they would have a second staff member attempt to complete the care. PSW #123 also identified that the resident rarely demonstrated their specific responsive behaviours with them because they would use specific interventions. PSW #103 stated that they would expect these interventions be identified within the resident's care plan as they "rarely" had issues providing care to resident #020, once implementing these interventions.

Inspector #638 reviewed resident #020 health care records and identified in their care plan an intervention to approach the resident in a specific manner. The Inspector was unable to identify any of the aforementioned interventions provided by the PSWs within resident #020’s care plan.

The home’s policy titled “Responsive Behaviors Program – NUM VII – 50” last reviewed June 2017, indicated that the resident’s plan of care should be established adapting resident focused, interdisciplinary goals and strategies to ensure resident well-being and quality of life.

During an interview with Inspector #638, the DOC/Administrator indicated that they were currently in the process of revising resident #020’s care plan as they had recently completed a care conference and some inconsistencies regarding interventions for their specific responsive behaviours had been identified. The DOC/Administrator indicated that the resident’s care plan should have included the interventions that worked for resident #020, so any staff member could have implemented these interventions effectively. [s. 53. (1) 2.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviour to meet the needs of resident #020 and any other resident with responsive behaviours, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production**

**Specifically failed to comply with the following:**

**s. 72. (2) The food production system must, at a minimum, provide for,**
**(c) standardized recipes and production sheets for all menus; O. Reg. 79/10, s. 72 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the food production system provided standardized recipes for all menus.

Inspector #679 observed the lunch meal service on January 22, 2018. The daily menu indicated minestrone soup in a regular texture. The remaining menu items were offered in regular, minced and pureed textures.

In an interview with Inspector #679, DA #109 indicated that the soup was not a pureed consistency and they would put the soup in the blender to puree it. The DA indicated that there was no formal direction as to how long to blend the soup to ensure a pureed consistency and that they looked at the consistency to ensure there were no "chunks".

Inspector #679 observed a dinner meal service on January 31, 2018. The daily menu identified that the dessert options were fresh fruit or jello.

During an interview with DA #133, Inspector #679 inquired if each dessert option was available in a regular, minced and pureed texture. The DA indicated that they could use the blender to puree a banana for those who were on a pureed texture.

During an interview with Inspector #679, the RD indicated that the home did not have a standard recipe for certain items, to their knowledge. The RD indicated that there should be a standardized recipe for specific textures, as some foods required thickeners when pureed.

In an interview with Inspector #679, the FSM indicated that there were standardized recipes for the menu items and that the pureed meals were pre-packaged when ordered. The FSM identified that blenders on the units were used to puree food for residents if they wanted the alternative meal options. The FSM indicated that there were no formal directions for the staff to puree foods and that staff were only educated to observe the appearance of the food. The FSM further indicated that the DAs would add thickener according to the visual appearance once pureed. [s. 72. (2) (c)]

***Additional Required Actions:***

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

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, procedures were developed and implemented to ensure that there was a process to report and locate resident’s lost clothing and personal items.

A complaint was submitted to the Director which indicated that resident #009 had ongoing concerns related to missing clothing. During an interview with resident #009’s family, they stated that they purchased clothing right after the resident’s admission and have been bringing clothing in on a regular basis as some of resident #009’s personal clothing were missing. They indicated that they had spoken to numerous staff with no resolution.

The home's policy titled, "Resident's Personal Belongings" last reviewed October 2012, indicated that, all personal effects of the resident were to be treated with respect. Resident's clothing must be identified, either by the use of labels or laundry markers. The policy indicated every attempt will be made to locate lost clothing.

In an interview with Inspector #687, PSW #105 stated that the process for reporting resident’s missing clothing was to write a note and leave it at the nurses station. The note would be included in the shift report, staff would search the laundry department and the lost and found.

During an interview with Inspector #687, RPN #104 indicated that the home's process for locating missing clothing was for staff to look in the lost and found bin, contact laundry services to initiate a search and the staff should include the missing clothing information in the shift report. The RPN indicated that there was no formal process to track the status of missing clothing.

In an interview with Inspector #687, the DOC/Administrator stated that the home did not have a formal process to report and locate residents missing clothing or belongings. The DOC/Administrator further stated that staff would search for the missing articles in the resident's room, report the items to the laundry department and search the lost and found bin. [s. 89. (1) (a) (iv)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there are procedures developed and implemented to ensure that there is a process to report and locate resident's lost clothing and personal items, to be implemented voluntarily.***

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.**

**Findings/Faits saillants :**

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

During a tour of the home, Inspector #679 observed a clean utility room with the door unlatched and unattended. The utility room contained the following substances;
-one bottle of "Arjo-Huntleigh disinfectant IV",
-three bottles of "Arjo-Huntleigh sure wash disinfectant", and
-one bottle of "Arjo-Huntleigh sure rinse soiled utility room descaler".

A review of the Material Safety Data Sheets (MSDS) outlined the following hazard statements for each of the substances;
-Arjo-Huntleigh disinfectant IV cleaner "causes severe skin burns and eye damage";
-Arjo-Huntleigh sure wash "may cause eye and skin irritation"; and
-Arjo-Huntleigh sure rinse "causes serious eye irritation and skin irritation".

On five separate occasions between January 23, 2018, and January 30, 2018, Inspector #679 observed the clean utility room unlatched an unattended. On January 25, 2018, Inspector #679 observed a note on the utility room door, which indicated that staff were to "ensure the door was latched upon exiting", but the door remained unlatched and unattended during this observation.

In an interview with Inspector #679, PSW #113 indicated that the door to the clean utility room should remain closed and locked when not being accessed by staff.

During an interview with Inspector #679, Housekeeping Aid #117 indicated that the clean utility room door was supposed to remain closed and locked at all times, they further indicated that staff were supposed to check the door to ensure it was closed properly as it didn't always latch.

A review of the policy entitled "Chemicals: HSK I-H-140" last reviewed October 2015, outlined that all chemicals were stored in a locked storage room, which were kept inaccessible to residents.

In an interview with Inspector #679, the DOC/Administrator stated that the clean utility room door was supposed to remain closed and locked. The DOC/Administrator indicated that the utility room door was not latching properly and that they placed a sign on the door to ensure the door was being closed when staff left the room. [s. 91.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances in the home are kept inaccessible to residents at all times, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device**

**Specifically failed to comply with the following:**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).**

**s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:**
**7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessment, reassessment and monitoring including the resident's response was documented.

a) Resident #013 was identified during an observation by Inspector #638, as having a potential restraint.

During a review of resident #013's health care records, the Inspector reviewed a "Restraint Effectiveness & Need Assessment/Reassessment Form". Out of the 24 days

reviewed, the Inspector identified seven day shifts and eight afternoon shifts where the reassessments had not been documented.

b) Resident #003 was identified by Inspector #679, through a resident observation, as having a potential restraint.

Inspector #679 reviewed resident #003's "Restraint Effectiveness & Need Assessment/Reassessment Form" and identified that there was missing documentation on 13 of the 25 days reviewed, or missing partial documentation for 52 per cent of the days reviewed.

In an interview with Inspector #638, RPN #102 indicated that registered staff were in charge of reassessing each resident's restraint, each shift. The RPN stated that they documented this reassessment on the paper chart at the nurses' station ("Restraint Effectiveness & Need Assessment/Reassessment Form"). The Inspector reviewed the reassessment forms with the RPN who identified multiple inconsistencies with documentation. The RPN stated that the form should have been filled out in entirety to document that the assessment of the resident's restraint had been completed.

The home's policy titled "Restraints: Minimizing Restraining of Residents and Use of Restraints & PASD Program - NUM VII-55" last revised March 2017, indicated that registered nursing staff were required to reassess the resident's responses and ability to tolerate the restraint every eight hours.

During an interview with Inspector #638, the DOC/Administrator indicated that registered staff took the lead role in the implementation and reassessment of resident specific restraints. Upon reviewing the reassessment record with the DOC/Administrator, they indicated that the reassessment form ("Restraint Effectiveness & Need Assessment/Reassessment Form") should not have had any gaps and should have been completed in entirety. [s. 110. (7) 6.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that every release of the device and all repositioning was documented.

a) Resident #013 was identified during an observation by Inspector #638, as having a potential restraint.

Inspector #638 reviewed resident #013's health care records and identified a "Restraint Observation Form" which identified that the resident had a specific restraint for safety. The record identified whenever the resident's device was applied, removed or if the resident was checked and repositioned. The Inspector reviewed the "Restraint Observation Form", which identified that on 13 out of 25 days, or on 52 per cent of the days, the resident's record was only partially complete.

b) Resident #003 was identified by Inspector #679, through a resident observation, as having a potential restraint.

Inspector #679 reviewed resident #003's health care records and identified in their care plan that the resident used a specific restraint. The Inspector reviewed the "Restraint Observation Form" for the resident's tabletop and wheelchair seat belt restraints and identified that the documentation regarding resident monitoring and repositioning was not completed in entirety on ten out of 25 days, or 40 per cent of the days reviewed.

In an interview with Inspector #638, PSW #103 indicated that the PSWs assumed the role of applying and managing restraint interventions. The PSW stated that all restraint care was documented on the "Restraint Observation Form". Upon reviewing resident #013's record with the PSW, they stated that the form should have been completed in entirety, even if the restraint was not applied.

During an interview with Inspector #638, RPN #102 stated that PSWs generally implemented and managed resident restraints, but registered staff were to assess the device every shift. The RPN indicated that the PSWs should have filled out the "Restraint Observation Form" in entirety.

The home's policy titled "Restraints: Minimizing Restraining of Residents and Use of Restraints & PASD Program - NUM VII-55" last revised March 2017, indicated that the interdisciplinary team were to document every hour on restraint monitoring record and every two hours when the restraint was released and the resident was repositioned and care plan interventions had been followed.

In an interview with Inspector #638, the DOC/Administrator indicated that PSWs completed most care surrounding resident restraints. The Inspector reviewed resident #013's "Restraint Observation Form" with the DOC/Administrator, who indicated that there should not have been any gaps in documentation related to the resident's restraint

and it should have been completed in entirety. [s. 110. (7) 7.]

***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 release of the restraining device and all repositioning is documented, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every resident had the right to have their personal health information within the meaning of the PHIPA, 2004, kept confidential in accordance with the Act.

Inspector #638 observed a medication pass. The Inspector observed RPN #102 removing resident medications from their specific medication strips (which included resident health information) and dispose of the strips in the garbage can.

In an interview with Inspector #638, RPN #102 indicated that the strips would wear down eventually once thrown in the garbage, but they did not alter the strip prior to throwing them out. The RPN indicated that this was the home's process and they believed they were informed by the pharmacist that this was an acceptable practice.

During an interview with Inspector #638, RPN #114 and RPN #124 both indicated that they were trained to place the strips in a container and fill the container with water, as this would remove the writing from the medication strips to ensure confidentiality of resident health information.

Inspector #638 interviewed the DOC/Administrator who indicated that they have witnessed registered staff throwing the medication strips in the garbage and had not previously considered resident health information, but they did identify that there would be no way of ensuring the resident's information was kept confidential without the strips being altered prior to being thrown out. [s. 3. (1) 11. iv.]

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

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

Inspector #687 observed resident #009 on two separate dates. The Inspector observed that the resident's call bell was wrapped on the left hand side of the bed rail (inaccessible to the resident) and the "versus" call system badge was attached to the back of the resident's mobility assistance device.

A record review of resident #009's care plan indicated that the resident's call bell was to be within reach of the resident and that the staff were supposed to encourage the resident to use their call bell when requiring assistance.

During an interview with Inspector #687, PSW #115 stated that resident #009 was unable to use their call bell. The PSW indicated the "versus" badge was clipped to the back of the resident's mobility assistance device as the resident would throw it out if it was clipped to their clothing.

In an interview with Inspector #687, RPN #104 indicated that resident #009 had a call

bell, but the resident was unable to use the call bell. The RPN stated that the staff would complete frequent checks on the resident but acknowledged that there was no documented interventions for staff rounds on day shift to check on resident #009.

The home's policy titled "Versus System Audit Control - VII-100" last reviewed November 2015, outlined that the home shall ensure that the home was equipped with a resident-staff communication and response system, that could be easily seen, accessed and used by residents, staff and visitors at all times. The policy indicated that the communication system should be on at all times, available at each bed, toilet, bath and shower location used by residents, and available in every area accessible by residents.

During an interview with Inspector #687, the DOC/Administrator stated that a resident must have access to their call bell at all times. The DOC/Administrator indicated that resident #009 had cognitive deficits, but the resident should still have access to a call bell. [s. 17. (1) (a)]

2. During multiple observations made by Inspector #679 and Inspector #638, it was identified that the call bell cord was missing from resident #017's bathroom and resident #018's bedside and bathroom. Furthermore, the following call bells were also found not functioning;
-resident #001's bedside call bell;
-resident #003's bathroom call bell;
-resident #012's bedside call bell; and
-resident #019's bedside call bell.

Inspector #679 tested the call bells for resident #001, #003 and #012. None of the call bells alarmed to notify staff that the bell had been activated. In an interview with resident #001, they identified to the Inspector, that the call bell at their bedside did not work.

In an interview with Inspector #679, PSW #113 stated that each resident was supposed to have a call bell at their bedside, a call bell in their bedroom and a "versus" badge.

During an interview with Inspector #679, RPN #124 stated that each resident was supposed to have a functioning call bell available at their bedside, in their bathroom and a "versus" badge applied to the resident.

In an interview with the Inspector, the DOC/Administrator stated that each resident room was supposed to have a functioning call bell at the resident's bedside and in their

bathroom. The DOC/Administrator indicated that staff encouraged the residents to use their "versus" badge first and that the bedside bell and bathroom bells were to be used as a backup. [s. 17. (1) (a)]

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the organized program under section 48 of the Ontario Regulation 79/10 was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices

According to s. 48. (1) 1. of the O. Reg. 79/10, the licensee shall ensure that a falls prevention and management program to reduce the incidence of falls and risk of injury are developed and implemented in the home.

A CIS report was submitted to the Director for an incident that caused an injury to a resident, for which the resident was taken to hospital. Please refer to WN #2 finding 3 for details.

Inspector #679 reviewed the home's policy titled "Fall Prevention/ Management Program - NUM III-27" which indicated that the policy was last revised in April 2016.

In an interview with Inspector #679, the DOC/Administrator identified that they did not have any documentation to support that the falls program had been updated since April 2016. [s. 30. (1) 3.]

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Inspector #679 reviewed a complaint submitted to the Director related to staffing issues in the home. The complaint alleged that the home was often short staffed, which resulted in residents having to wait long periods of time for care. Please refer to WN #1 finding 1 for details.

Inspector #679 reviewed the home's policy titled "Written Staffing Plan/Pattern/Contingency Plan - NUR VII-90" and identified that the policy was last reviewed December 2015. The policy identified that the staffing plan was evaluated annually or when required and that a written record would include the date of the evaluation, the names of those who participated and a summary of the changes made to the policy.

In an interview with Inspector #679, the DOC/Administrator indicated that they did not have any documentation to support that the staffing plan had been reviewed since December 2015. [s. 31. (3)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**

**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was submitted to the Director which indicated that resident #020 was not

receiving their scheduled baths and that they often went long periods of time without a bath because of the resident's specific responsive behaviours. In an interview with the complainant they indicated that they provided the resident with care when possible, but they had ongoing concerns with staff, indicating that the resident often missed their baths.

Inspector #638 reviewed the resident #020's bathing record over a three month period in 2017, and 2018. Upon reviewing the resident's bath list, it was identified that the resident went for their shower on two specific days each week. It was identified through the review of the bathing record that there were multiple occasions where the resident went an extended period of time without receiving their scheduled bath;
-In November 2017, the resident went nine days without a bath, the care was documented as "Activity Did Not Occur" on the dates of their scheduled baths,
-In December 2017, the resident went 16 days without a bath, the care was documented as "Activity Did Not Occur" or "Refused" on the dates of their scheduled baths, and
-In January 2018, the resident went ten days without a bath, the care was documented as "Activity Did Not Occur" on the dates of their scheduled baths.

Out of the 26 scheduled baths the resident was supposed to receive over the three month review period, it was documented that the resident missed 15 baths, or 57 per cent of their scheduled baths.

In an interview with Inspector #638, PSW #103 indicated that resident #020's care should have been completed as per their plan of care. The PSW stated that the resident was often bathed once a week and that the family was okay with that. The Inspector reviewed the bathing record with the PSW, who indicated that the resident's family may have provided the resident with a shower on some of the dates indicating "activity did not occur", but they would not be able to determine if the resident received their shower on these dates because it appeared that the care had not been provided according to the documentation.

The Inspector reviewed resident #020's care plan and was unable to identify any intervention indicating that it would be acceptable for the resident to be showered once a week instead of the requirements laid out within s. 33 (1) of the O. Reg. 79/10.

During an interview with Inspector #638, PSW #123 stated that they sometimes provided care for resident #020 and indicated that the resident may refuse their shower at times, but upon re-approaching the resident, they were rarely resistant. The PSW stated that if

the activity did not occur, they would expect a progress note to be written identifying why the care was not provided.

The Inspector reviewed resident #020's progress notes and was unable to identify any notation during the aforementioned times regarding why the resident's bathing record was identified as "activity did not occur".

In an interview with Inspector #638, the DOC/Administrator indicated that staff should provide resident #020 with their scheduled baths twice weekly as identified in their plan of care. The Inspector reviewed resident #020's bathing record with the DOC/Administrator who indicated that they were not sure why care was documented as "activity did not occur", but they indicated that sometimes the resident's family provided their care. They indicated that in these circumstances the staff should have ensured that the shower was completed and documented the care as complete or have a registered staff member create a progress note to identify that the care was completed. The DOC/Administrator indicated that the "activity did not occur" notation appeared as though the resident did not receive their scheduled showers. [s. 33. (1)]

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

**Specifically failed to comply with the following:**

**s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director.

An incident was reported to the Director via the after hours reporting number on a specific date in 2017. The incident alleged that resident #014 was physically abused by a staff member in the home. Inspector #638 reviewed the intake which had an after hours pager report attached. The Inspector reviewed the "www.ltchomes.net" reporting site and was unable to identify a CIS report which was completed or related to this incident.

In an interview with Inspector #638, RPN #102 indicated that when an incident of abuse was suspected they were supposed to ensure resident safety, complete a quick review of the incident and report these findings to the DOC/Administrator to complete the remaining requirements.

The home's policy titled "Zero Tolerance of Abuse and Neglect - NUM VII-7" last reviewed June 2016, indicated that when the Administrator/DOC was not in attendance, the Charge Nurse on duty was to lead the investigation and was to utilize the after hours Ministry of Health and Long-Term Care (MOHLTC) reporting number upon establishing reasonable grounds. The policy identified that management staff were to report to the MOHLTC Director the results of every investigation the home conducted.

In an interview with Inspector #638, the DOC/Administrator stated that they were unable to locate a completed CIS report regarding resident #014's incident of alleged staff to resident physical abuse. They indicated that they were unaware (at the time of the incident) that it was their role to complete the CIS report to the Director, as they believed it was a role of the registered staff. [s. 104. (2)]

**Issued on this 9th day of March, 2018**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | RYAN GOODMURPHY (638), LOVIRIZA CALUZA (687), MICHELLE BERARDI (679) |
| **Inspection No. / No de l'inspection :** | 2018_615638_0002 |
| **Log No. / No de registre :** | 000633-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Mar 1, 2018 |
| **Licensee / Titulaire de permis :** | St. Joseph's General Hospital Elliot Lake<br>70 Spine Road, ELLIOT LAKE, ON, P5A-1X2 |
| **LTC Home / Foyer de SLD :** | St. Joseph's Manor<br>70 Spine Road, ELLIOT LAKE, ON, P5A-1X2 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Cynthia Farquhar |

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)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

**Order / Ordre :**

The licensee shall;

1. develop and implement a process to ensure that resident call bells are answered and resident needs are met in a timely manner, regardless of staffing levels within the home.

2. audit the home's call bell wait times, to ensure that residents' needs are being met in a timely manner.

3. evaluate the home's staffing plan on a regular basis, according to section 31 (3) of the Ontario Regulation 79/10, to address staffing shortages in order to ensure that there is an organized program of personal support services for the home that meets the assessed needs of the residents.

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #679 reviewed a complaint submitted to the Director related to staffing issues in the home. The complaint alleged that the home was often short staffed, resulting in residents having to wait a prolonged period of time for care. The complaint further identified that call bells were not being answered and that

resident care was being jeopardized.

According to s. 8 (2) of the Long Term Care Homes Act (LTCHA),2007, personal support services means services to assist with the activities of daily living, including personal hygiene services and includes supervision in carrying out those activities.

a) During an observation, Inspector #679 identified that resident #015's call bell was ringing for approximately 25 minutes. During another observation, Inspector #679 observed that resident #022's call bell had been ringing for approximately 26 minutes.

In an interview with Inspector #679, resident #015 identified that they were waiting for assistance with continence care.

During an interview with Inspector #679, resident #022 identified that they felt that the home was always short staffed and that they had to wait long periods of time for staff to assist them with their care needs.

b) Inspector #679 reviewed the staffing schedule over a 14 day period in January 2018. The Inspector identified eight dates the home was short at least one PSW and on four of those dates, the home worked short two PSWs.

Inspector #679 reviewed the "versus" call bell system record to identify resident call bell response times, when the home worked two PSWs short. Upon review, the Inspector identified one occasion that a resident call bell was active for one hour and four minutes. The Inspector noted that over a three day period in which the home was short staffed, there were approximately 64 occasions in which residents had to wait more than ten minutes for staff to respond to their call bell and approximately 36 of these calls were greater than 20 minute wait times.

In an interview with Inspector #679, PSW #108 indicated that when the home was short staffed, the residents had to wait up to ten minutes for their call bell to be answered, due to increased workload.

Inspector #679 reviewed the "versus" call bell system record with PSW #110. Upon review, the PSW stated that the frequently recorded wait times of 17 or 20 minutes was too long.

In an interview with Inspector #679, RPN #124 stated that an acceptable time for resident's to wait for a response when they rang their call bell, would be approximately five minutes.

In an interview with Inspector #679, the DOC/Administrator indicated that the wait time for a response when a call bell was initiated, should be less than five minutes. The DOC/Administrator stated, in some cases when staff were responding to other residents, the wait times may be longer. The DOC/Administrator identified that the wait times identified were concerning and acknowledged that the recorded times outlined in the "verus" report were excessive.

During previous inspections, there were numerous unrelated non compliances within the past 36 months. The decision to issue a compliance order was based on the severity which indicates a potential risk of actual harm of the residents. Furthermore, the scope of this non compliance is considered widespread as direct care staffing has the potential to impact every resident. Although the compliance history was unrelated, the scope and severity had significant risk of harm to residents requiring assistance with their care needs. (679)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 29, 2018

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

**Order / Ordre :**

The licensee shall;

1. ensure that the Administrator/Director of Care is not considered to be a registered nurse while working in the capacity of an Administrator or Director of Care.

2. implement a recruitment and retention strategy to ensure that there is an adequate staffing compliment of registered nurses available to attend the home when there are vacant shifts.

**Grounds / Motifs :**

1. The licensee has failed to ensure that during the hours that an Administrator or Director of Nursing and Personal Care worked in that capacity, they were not considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

Inspector #679 reviewed a complaint submitted to the Director related to staffing concerns. The complaint alleged that the home was often short staffed, which resulted in residents having to wait long periods of time for care. The complaint further identified that call bells were not being answered in a timely manner and that resident care was being jeopardized.

In an interview with Inspector #638, the DOC/Administrator identified that they were both the DOC and Administrator of the home. The home was identified as

having a licensed capacity of 64 beds.

According to s. 212 (1) of the O. Reg. 79/10, the licensee was to ensure that the home's Administrator worked regularly in that position on site at the home at least 16 hours per week in a home with a licensed bed capacity of 64 beds or fewer.

According to s. 213 (1) of the O. Reg 79/10, the licensee was to ensure that the home's Director of Nursing and Personal Care worked regularly on site at the home at least 24 hours per week in a home with a licensed bed capacity of more than 39 but fewer than 65 beds.

Inspector #679 reviewed a document provided by the DOC/Administrator. The document outlined the number of days they worked as an RN in the home since they initiated their role as DOC/Administrator in June 2017. The document identified that they worked 344 hours in the capacity of a RN, while fulfilling their role as the DOC and the Administrator.

In an interview with Inspector #679, the DOC/Administrator identified that the home had issues with RN staffing. They indicated that they worked in the capacity of an RN for approximately 300 hours since being employed in the home (June 2017). The DOC/Administrator stated they had not been able to make up the hours that they spent working as an RN, while working in the capacity of a DOC/Administrator.

During previous inspection #2016_463616_0004 a compliance order was issued to the home on March 21, 2016, related to the Long-Term Care Homes Act (LTCHA), 2007, s. 8 (3). The compliance order was complied on June 29, 2016. The decision to issue this compliance order was based on the severity which indicates a potential risk of actual harm. The scope was widespread and there was a compliance history previously issued under this section of the Act related to 24 hour nursing care. (638)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 29, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

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

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

**Issued on this  1st  day of March, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Name of Inspector / Nom de l'inspecteur :** Ryan Goodmurphy

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