Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2017;	2017_615638_0012 (A1)	009430-17	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

RYAN GOODMURPHY (638) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Order #001, compliance due date extended until November 24, 2017.

Issued on this 27 day of September 2017 (A1)

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

Original report signed by the inspector.

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RYAN GOODMURPHY (638) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 19-23 and 26-30, 2017.

The following intakes were completed during this Resident Quality Inspection:

-One log was related to CO #001 from Inspection report #2016_273638_0020, s. 15 (1) of the Long-Term Care Homes Act (LTCHA), 2007, specific to the home's bed rail systems.

-One log was related to CO #002 from Inspection report #2016_273638_0020, s. 50 (2) of the Ontario Regulation (O. Reg.) 79/10, specific to skin integrity and wound assessments.

-One log was related to CO #003 from Inspection report #2016_273638_0020, s. 101 (2) of the O. Reg. 79/10, specific to the home's complaint process.

-One log was related to CO #004 from Inspection report #2016_273638_0020, s. 6 (7) of the LTCHA, 2007, specific to care being provided as per the plan of care.

-One log was related to CO #005 from Inspection report #2016_273638_0020, s. 6 (10) of the LTCHA, 2007, specific to the revision of the plan of care, when the resident's care needs change.

-One log was related to CO #006 from Inspection report #2016_273638_0020, s. 73 (1) of the O. Reg. 79/10, specific to feeding and positioning techniques while assisting residents with feeding.

-One log was a complaint submitted to the Director which was related to allegations of improper care, meal services and Substitute Decision Maker

(SDM) not being notified of changes in resident status.

-One log was a complaint submitted to the Director which was related to personal property missing, skin integrity concerns, and SDM not notified of changes in the residents status.

-One log was a complaint submitted to the Director which was related to allegation of improper care, falls management, worsening behaviours and SDM not notified of change in the resident's status.

-One log was a complaint submitted to the Director which was related to insufficient staffing and meal service concerns.

-Two logs were complaints submitted to the Director which were related to housekeeping concerns as well as allegation of improper care and neglect.

-One log was related to a critical incident the home submitted to the Director regarding an incident in which resulted in a change in status.

-Two logs were critical incident reports related to medication management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Risk Quality and Accreditation (RQA) Lead, Program Coordinator, Food Service Manager (FSM), Chaplain, Social Worker (SW), Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and their families.

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:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

10 WN(s)
4 VPC(s)
2 CO(s)
2 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. 101. (2)	CO #003	2016_273638_0020	627
O.Reg 79/10 s. 15. (1)	CO #001	2016_273638_0020	543
LTCHA, 2007 s. 6. (10)	CO #005	2016_273638_0020	638
O.Reg 79/10 s. 73. (1)	CO #006	2016_273638_0020	681

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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessments of the resident so that their assessments were integrated and were consistent with and complemented each other.

A Critical Incident Systems (CIS) report was submitted to the Director, which indicated that resident #003 had demonstrated specific responsive behaviours towards resident #024 in June 2017, which resulted in harm to resident #024.

Inspector #627 reviewed resident #003's progress notes which identified that the resident had a significant history of specific responsive behaviours. It was identified that the resident demonstrated a specific responsive behaviour towards staff and residents on multiple occasions between May 2017, and June 2017. During this review period resident #003 demonstrated specific responsive behaviours on three occasions in April 2017, nine instances in May 2017, and on five occasions in June 2017.

Inspector #638 identified a progress noted for resident #003, dated June 2017,

which identified that RN #122 requested specific documentation to send the resident out for assessment to better manage their responsive behaviours. The progress notes further indicated that the home initiated a specific referral for resident #003 and obtained consent from the Substitute Decision Maker (SDM) to initiate the referral so they could better manage the residents specific responsive behaviours.

Inspector #638 reviewed MD #141's response, written in the progress notes by RN #136, which indicated that the MD "was not agreeable" for a the specific referral or specific documentation to send the resident out for assessment and informed staff that the "resident's behaviours need to be dealt with internally, using the interventions that are already in place".

In an interview with Inspector #543, the DOC stated that resident #003 had ongoing specific responsive behaviours which were difficult to manage as the resident did not have specific triggers and the resident was very unpredictable. The DOC stated that the interventions in place were not working and that MD #141 was not cooperating with the home and their assessments or even accepting that the resident required additional supports to manage their behaviours. The DOC stated that MD #141 refused to sign the referral forms for the resident. [s. 6. (4) (a)]

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

During inspection #2016_273638_0020, compliance order (CO) #004 was served to the licensee on February 9, 2017, related to the provision of care as per the resident's care plan, which ordered the licensee to;
"a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001, #002, #025 and #027.
b) Develop and implement a system to ensure that all front line staff involved in the care of residents in the home, review the residents' plans of care and are kept aware of every residents' most up to date plans of care as changes occur.
c) Provide retraining to all staff (PSWs, RPNs and RNs) involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care and maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

While the licensee had complied sections "b and c", section "a", where the licensee was ordered to ensure that every resident in the home was provided with care as specified in their respective plans of care was not complied with.

Inspector #681 observed the lunch meal service in a home area on June 28, 2017. The Inspector observed resident #018 was seated in a specific position while being assisted with their meal.

During a review of resident #018's care plan, the Inspector noted that the resident was supposed to be positioned in the aforementioned position except while at meals. The care plan further identified that the resident required specific directions while eating.

In an interview with Inspector #681, RPN #113 acknowledged that the care plan for resident #018 indicated that they should not be position in the aforementioned position during meal services. The Inspector observed RPN #113 reposition the resident in their seat.

The home's policy titled "Careplanning" last revised December 6, 2016, indicated that the inter-professional team was required to provide care to the resident as it was set out in the plan.

During an interview with Inspector #681, the RD stated that all residents should be seated at a 90 degree angle during meal services, unless it was otherwise indicated in their care plan. [s. 6. (7)]

3. A complaint was submitted to the Director which alleged that staff were not thickening the residents fluids as per their assessed needs.

a) During the breakfast meal service in a specific home area, Inspector #681 observed three beverages in front of resident #015. One of the thickened fluids appeared too thick and held it's shape on the spoon.

Inspector #681 reviewed resident #015's electronic care plan which indicated that the resident was to receive fluids that were a honey thick consistency.

b) During a lunch meal service in a specific home area, resident #020 told Inspector #681 that they were unable to drink their thickened juice. The resident stated they were not able to drink their fluids because it was too thick and became

stuck to the bottom of the cup.

Inspector #681 reviewed resident #020's care plan which indicated that they were supposed to receive fluids that were nectar thick in consistency.

In an interview with the Inspector, PSW #103 stated that they prepared resident #020's thickened fluids for the lunch meal service on the day of the observation, as per the instructions on the beverage cart. The PSW stated that resident #020's fluids appeared to be thicker than a nectar thick consistency.

c) Inspector observed resident #021 during the lunch meal service on another home area. Resident #021 was being fed thickened fluids using a spoon. The fluid was thickened to the point that it was holding the shape of the spoon.

Inspector #681 reviewed resident #021's care plan which indicated that the resident was supposed to receive fluids that were a honey thick consistency.

During an interview with Inspector #681, the FSM provided the Inspector with the following descriptions for thickened fluids:
-Nectar thick: fluid runs freely off the spoon but leaves a thin coating on the spoon, the fluids should pour like most types of fruit nectar.
-Honey thick: fluid slowly drips in dollops off the end of the spoon, the fluids should pour slowly like liquid honey
-Pudding thick: fluid sits on the spoon and does not flow off, the fluids should be as thick as pudding.

In an interview with Inspector #681 on June 28, 2017, RD # 123 acknowledged that the thickened beverage from resident #015 was pudding thick consistency instead of honey thick consistency. The RD further indicated that there had been an ongoing issue with thickening of fluids and they had completed audits in June 2017.

Inspector #638 reviewed the "Thickened Fluids Audit" completed by the RD on three home areas over a two day period in June 2017. The Inspector identified that the RD noted during the audit that staff did not refer to the "Thicken Up preparation chart" or follow the mixing instructions when thickening fluids. The Inspector further identified that on two of the three home areas audited, staff did not use the proper measuring spoon to thicken their fluids. [s. 6. (7)]

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

As a result of multiple family interviews and multiple complaints submitted to the Director, insufficient staffing was identified as a potential risk for resident's in the home by the Inspectors.

Inspector #638 reviewed a scheduling record provided by the Scheduling Coordinator, which identified each shift in May 2017, that the home worked short. During this review period, the Inspector identified that during five day shifts in May 2017, and during six afternoon shifts in May 2017, the home worked at least two PSWs short staffed.

The Inspector reviewed multiple dates that the home worked short staffed (working plan b). In the review, the Inspector identified that there was a lack of documentation on one day shift in a specific home area in May 2017. The documentation for nine out of the 32 residents on the unit or 28 per cent was noted as incomplete. During another day shift in May 2017, where the home worked short staffed, one home area's documentation was noted as incomplete for 21 out of 32 residents or 66 per cent incomplete and on another home area on a specific day in May 2017, the day shift documentation was incomplete for 15 out of 31 residents or 48 per cent.

Inspector #638 reviewed the incomplete documentation on one specific day in May 2017, for resident #025, #026 and #027. The Inspector identified that resident #025 was missing numerous types of their Point of Care (POC) documentation. Resident #026 was also lacking numerous types of their documentation and resident #027 was also missing numerous types of documentation.

During an interview with Inspector #638, PSW #117 stated that the daily care provided by the PSW was documented in POC. The PSW stated that the resident's POC documentation should be completed in entirety to demonstrate the care the resident received. The PSW also stated that if they were having difficulties completing their documentation that they should notify registered staff so that registered staff could adjust workload to ensure that the documentation was completed as expected.

In an interview with PSW #131, they stated that they were working on one of the aforementioned days during the day shift. The PSW indicated that they were

working short on the unit on the specific shift in May 2017, and were in "plan b". The PSW identified that they had not completed certain aspects of their charting as when staff were working in "plan b" in May they had a float PSW who would assist with care. PSW #131 stated that this was changed due to documentation concerns as there was no clear direction on which staff member was expected to document on the care provided.

Inspector #638 interviewed RPN #102 who stated in the past, when the home was short staffed and working in "plan b", a PSW would be assigned as float staff between two units to assist with workload. They stated that the float staff did not work well in the home as they did not have a scripted routine and roles. RPN #102 stated that even when working short staffed, they were expected to complete their documentation.

The home’s policy titled “Documentation” – Clinical Services last revised January 2017, identified that all significant information about the resident was documented in their health record. The policy further identified that staff were required to document care and services provided.

In an interview with Inspector #638, the Administrator stated that the previous DOC implemented the "plan b" staffing plan which included a float PSW. The administrator indicated that due to ongoing concerns, the current DOC changed the "plan b" staffing plan to no longer include a float staff. The Administrator stated that all documentation was expected to be completed.

In an interview with Inspector #638, the DOC indicated that staff were expected to complete their POC charting on each resident. The DOC also stated that if staff were having difficulty in completing their documentation that they would have been expected to be notified of these issues so that time would be allotted to complete their required documentation. [s. 6. (9) 1.]

5. A complaint was submitted to the Director which alleged improper care when resident #014 was left with a specific intervention applied longer than what was assessed, which caused a negative outcome for the resident on a specific day in April 2017.

Inspector #638 reviewed resident #014's progress notes and identified that the resident was found in the morning with their specific intervention still applied from the previous day. The progress notes further identified that when the specific

intervention was removed, the resident's extremities were both swollen and a discolouration was noted to their extremities.

Inspector #638 reviewed resident #014's care plan in place at the time of the incident. The Inspector identified an intervention related to a particular focus which directed staff to apply the resident's specific intervention in the morning and remove at night.

Inspector #638 reviewed resident #014's health care records for the evening shift in April 2017, prior to when the resident was found with their intervention still applied and was unable to identify any documentation of care provided on the evening shift. The Inspector reviewed the POC documentation and none of the resident's Activities of Daily Living (ADL) documentation had been completed.

In an interview with Inspector #638, the DOC stated that staff were expected to complete their POC documentation on each resident. [s. 6. (9) 1.]

Additional Required Actions:

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

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

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

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

WN #2: 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 was exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During inspection #2016_273638_0020, compliance order (CO) #002 was served to the licensee on February 9, 2017, related to the provision of care as per the resident's care plan, which ordered the licensee to;
"ensure that all residents at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital and any other time when a resident is exhibiting altered skin integrity, including pressure ulcers, skin breakdown, skin tears or wounds."

While the licensee had complied with the requirements of CO #002, non-compliance was identified after the compliance date of March 17, 2017.

During an interview with Inspector #627, RN #143 stated that resident #002 had an area of altered skin integrity. Resident #002 was also identified as having an area

of altered skin integrity to a specific location through a record review by Inspector #627.

During an interview with Inspector #627, RN #114 stated that resident #002 had an area of altered skin integrity to a specific location and the resident had specific interventions implemented to manage the area of altered skin integrity. The RN stated that a wound assessment should be completed and documented with every dressing change in the electronic progress notes.

Inspector #627 reviewed the home's policy titled "Wound and Skin Care Program" last revised June 2016, which indicated that wounds were to be assessed and documented on a weekly basis. The assessment of a specific type of altered skin integrity was to include: Stage/depth, location, surface area, odour, sinus tracts/undermining/tunneling, exudate, appearance of wound bed, condition of surrounding skin (periwound) and wound edges and assessment of pain.

Inspector #627 reviewed resident #002's electronic records between April 8, 2017, and June 27, 2017. In this review period the Inspector noted that the resident on three occasions went for a period of 14 days, 8 days and 10 days during the review period without a documented wound assessment, although the resident had received dressing changes during those periods.

During an interview with the Inspector, the DOC stated that a wound assessment should be completed at every dressing change and at a minimum a wound assessment should be completed weekly. Inspector #627 reviewed resident #002's electronic record with the DOC who confirmed that resident #002 had not received weekly wound assessments for the above stated periods of time, although they were receiving wound care treatment. [s. 50. (2) (b) (iv)]

2. Resident #008 was identified as having a worsening area of altered skin integrity through a Minimum Data Set (MDS) assessment.

Inspector #543 reviewed resident #008's progress notes, which indicated that the resident previously had an area of altered skin integrity to a specific area which was resolved in January 2017.

The Inspector reviewed resident #008's wound care assessments between December 2016, and January 2017, which indicated that weekly wound care assessments had not been completed regarding the resident's area of altered skin

integrity for 42 days.

In an interview with Inspector #543, RPN #119 verified that resident #008 previously had skin integrity issues. At the time of inspection the resident was receiving wound prevention care, but did not presently have any areas of altered skin integrity. They stated that when resident #008 had their area of altered skin integrity, a comprehensive wound assessment should have been completed weekly.

The home's policy titled "Wound and Skin Care Program" last revised June 6, 2016, indicated that a resident with a wound would receive a comprehensive reassessment, conducted weekly to determine wound progress and the effectiveness of the treatment plan.

During an interview with Inspector #543, the DOC verified that registered staff completed the wound assessments in the progress notes under the appropriate heading and they should be completed after every dressing change, or weekly. The DOC indicated prior to April 2017, the requirement was that staff completed the "Weekly Wound Assessment" for each wound weekly. The DOC reviewed resident #008's wound assessments and stated that there were missing assessments between the aforementioned dates. The DOC indicated that there were no assessments completed during the six week period identified. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy, respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

During the inspection, resident #017's SDM provided Inspector #627 with two complaint letters that they had submitted to the home in June 2017. Both complaint letters alleged improper care of resident #017.

Inspector #627 observed PSW #127 enter resident #017's room at 0934 hours. In an interview with the Inspector, the PSW stated that they checked the resident earlier in the morning to ensure the resident had not required continence care and found the resident not dressed appropriately. The PSW indicated that since the resident had not required continence care, they did not adjust the resident's clothing. They stated that the resident required a two person assist and that they were unable to move the resident on their own. The PSW also stated that the night shift staff had not dressed the resident appropriately.

During an interview with the Inspector, RPN #119 stated that all residents should be dressed in a dignified manner and that leaving a resident not dressed appropriately did not respect the resident's dignity. They stated that the PSW should have sought assistance to dress the resident.

During an interview with Inspector #627, the DOC stated that residents should be treated with dignity and that the PSW should have sought assistance to properly dress the resident. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident was properly fed, clothed, and groomed and cared for in a manner consistent with his or her needs.

During the inspection, the SDM of resident #017 provided Inspector #627 with a complaint letter that they had submitted to the home, in June 2017. The complaint letter alleged that on a specific day in June 2017, the resident had not been provided with morning care until the SDM had arrived at 1145 hours. The complaint letter indicated that the family member had opened the resident's door and witnessed the resident positioned in a disconcerting manner in their bed. The complaint letter identified that the resident also had been incontinent which had dried due to the length of time the resident had been left without continence care. Upon raising these concerns to RPN #119, the RPN informed the SDM that the PSW must have forgotten to provide care and breakfast to resident #017.

Inspector #627 reviewed resident #017's electronic chart, which revealed a progress note created by RPN #119 on the day of the alleged incident. The progress notes indicated that resident #017's family member had approached them at 1130 hours, asking why the resident was still in bed. The notes identified that RPN #119 assisted resident #017's SDM to provide care for the resident as the resident required continence care and was still in bed wearing their pajamas.

During an interview with the Inspector, PSW #126 stated that on specific days, the resident's private care giver did not come in. When the private care giver was not in, staff would provide care to resident #017.

In an interview with Inspector #627, RPN #119 stated that resident #017's SDM had approached them on the date of the alleged incident in June 2017, and requested that the RPN assist them with providing care for resident #017. The RPN stated that the resident required continence care, was still in their pajamas

and had not received their snack, which was usually provided at a specific time. The RPN further stated that the resident should have received their required care and in the dining room by their specified time for a snack.

In an interview with Inspector #638, the DOC stated that all residents should receive the care they required, in a manner consistent with their needs. [s. 3. (1) 4.]

3. The licensee has failed to ensure that resident #022's right to participate in decision-making was fully respected and promoted.

Two complaints were submitted to the Director. The two complaints were related to allegations of improper care towards resident #022, whereas the resident had requested to be sent to hospital and staff did not respect or follow the resident's wishes.

Inspector #543 reviewed resident #022's progress notes. The Inspector identified a notation made on a specific date in April 2017. In the note, RPN # 134 indicated that resident #022 had complained about their health status and requested a specific intervention to alleviate the issue. Another notation identified that RN #124 documented the resident was still coughing and that their specific intervention was not helping the resident much. The progress note identified that the resident had also requested to be sent to the hospital.

During an interview with Inspector #543, the complainant stated that when they spoke to RN #124 on the aforementioned date in April 2017, that they were extremely concerned that the resident would not be cared for adequately. The complainant stated that the RN informed them that the hospital would not do anything more for the resident than what was already being done in the home.

The Inspector requested the internal investigation notes from the DOC regarding the incident, whereby RN #124 refused to send resident #022 to the hospital. The documentation identified that an interview was held with the resident, SDM and DOC in May 2017. The interview notes indicated that the resident requested to be sent to the hospital on a specific date in April 2017. The resident stated they felt afraid that they were not feeling any better and fearful that they would not be able to breathe. When the resident was sent to the hospital for assessment later that day in April 2017, they were diagnosed with an illness and treatment was initiated. The home's internal investigation notes indicated that RN #124 did not follow the home's process and their actions were not consistent with the residents' rights.

In an interview with Inspector #543, the DOC stated that RN #124 had met with resident #022 in the morning of the specific date in April 2017, to discuss why the resident did not need to be sent to the hospital as per their request. They stated that RPN #134 attempted to contact the RN several times regarding the resident's request to be sent to the hospital. They stated the resident was sent to the hospital that evening and returned with a new diagnosis of an illness with treatment interventions in place. The DOC indicated that RN #124 had not followed the home's process and the resident had the right to be sent to hospital upon request. [s. 3. (1) 9.]

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 resident right is fully respected and promoted, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

The home's policy titled "Zero Tolerance for Abuse and Neglect", last reviewed September, 2016, indicated that once a staff member becomes aware of an alleged or witnessed incident of neglect, staff were expected to immediately report it to a supervisor. If the complaint was reported to supervisor, they should immediately report it to the Administrator or delegate.

During the inspection, the SDM of resident #017 provided Inspector #627 with a complaint letter that they had submitted to the home, on June 19, 2017. Please refer to WN #3 finding "2" for details.

During an interview with Inspector #627, RPN #119 stated that any complaints or allegations of neglect should be reported immediately to the DOC or ADOC. The RPN stated that if it was after hours, it should be reported to the RN. RPN #119 stated that they reported the incident to RN #124, although this had not been documented.

In an interview with the Inspector, RN #124 stated that they had been informed of the incident on the date of the incident in June 2017, by RPN #119, a few hours after the RPN became aware of the allegation of improper care. RPN #119 informed RN #124 that the family was upset that the resident was still in bed this morning. The RN stated that they had not considered this as an incident of neglect when they were notified. RN #124 reviewed the progress note written by RPN #119 regarding the incident on the day of the alleged incident in June 2017, and stated that the incident should had been reported as alleged neglect.

During an interview with Administrator and DOC, they stated that every alleged incident of neglect should be immediately reported to a supervisor. [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 to ensure that the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care identified any mood and behavior patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A CIS report was submitted to the Director, which alleged an incident of abuse between resident #003 and resident #024. The CIS report indicated that resident #003 was wandering the home area, grabbed resident #024 and displayed a specific responsive behaviour towards the resident. Resident #024 sustained an area of altered skin integrity as a result of the responsive behaviours of resident #003.

Inspector #627 reviewed resident #003's care plan and identified a foci of the

specific responsive behaviours, which identified risk to staff, however, there was no focus addressing the specific responsive behaviours towards other residents. Inspector #627 reviewed resident #003's progress notes between, April 1, 2017, to June 30, 2017, and identified 18 dates that the resident had displayed specific responsive behaviours towards other residents.

During an interview with the Inspector, PSW #137 stated that resident #003 occasionally demonstrated specific responsive behaviours towards residents. Whenever this occurs, resident # 003 should be redirected and specific interventions were to be implemented. PSW #137 indicated that the interventions to address the resident's specific responsive behaviours were found in their care plan.

In an interview with Inspector #627, PSW #117 stated that they had started working in the home very recently and they were assigned to resident #003. The PSW stated that the resident had certain behaviours, they indicated that they were not aware of resident #003 having the specific aforementioned responsive behaviours towards other residents. PSW #117 stated that they had reviewed resident #003's care plan prior to providing care to them.

During an interview with the Inspector, RN #124 stated that the resident's care plan was supposed to address the resident specific responsive behaviours. RN #124 reviewed resident #003's care plan and indicated that resident #003's specific responsive behaviours towards other residents had not been identified in their plan of care. The RN indicated that the immediately accessible plan of care had not identified the resident's specific responsive behaviours towards other residents.

Inspector #627 interviewed the DOC who stated that the plan of care should identify a resident's responsive behaviors and confirmed that resident #003's plan did not identify their risk of specific responsive behaviours toward other residents. [s. 26. (3) 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 to ensure that the plan of care for resident #003 identifies any mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in the residents functioning at different times of the day, to be implemented voluntarily.

WN #6: 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 has failed to ensure that each resident of the home had their personal items, including personal aids, labelled within 48 hours.

During the initial tour on June 19, 2017, Inspector #627 observed a used bar of soap in the Lakeview home area shower room as well as a used hairbrush, curling iron and tube of toothpaste in the Gardenway home area shower room. All these items were not labelled.

In an interview with Inspector #627, PSW #139 stated that they were not sure if the curling iron belonged to the home or resident. The PSW stated that all residents' personal items were to be labelled.

During an interview with Inspector #681, the ADOC stated that personal items were supposed to be labelled upon admission and after acquiring new items after admission. [s. 37. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, required heightened monitoring because those behaviours pose a potential risk to the resident or others.

A CIS report was submitted to the Director in June 2017, which alleged abuse between resident #003 and resident #024 on a specific date in June 2017. Please refer to WN #5 for details.

Inspector #638 reviewed the Dementia Observation System (DOS) charting for resident #003, which indicated that DOS charting was initiated on the date of the incident between resident #003 and resident #024 in June 2017, following the incident.

During an interview with Inspector #627, PSW #117 stated that they had started working in the home very recently and they were assigned resident #003. The PSW stated that resident #003 had certain responsive behaviours, the PSW stated that they were not aware of resident #003 having any specific aforementioned responsive behaviours towards other residents. PSW #117 further stated that resident #003's behaviours were not discussed at report prior to the beginning of the shift.

In an interview with Inspector #627, RPN #138 stated that they typically receive a written report from the previous shift, as well as a verbal report, however, they were only provided with a verbal report for their shift. After report, the RPN would relay the report to the PSWs which entailed all care concerns or issues involving the residents. The RPN stated that they were not aware of the incident that occurred two days prior to their shift, between resident #003 and #024. They stated that they assumed the DOS charting being completed for resident #003 was due to a medication change. RPN #138 stated that because they were not aware of the incident and they had not discussed resident #003's specific responsive behaviours with the PSWs during the shift report.

During an interview with the Inspector, the DOC stated that the front line staff would be made aware of any responsive behaviours that required monitoring at report prior to the beginning of the shift. As well, if any resident were on heightened monitoring such as DOS charting, the reason why the DOS charting was being completed was discussed at the report. [s. 55. (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, 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 were posted in the home, in a conspicuous and easily accessible location.

During the initial tour on June 19, 2017, Inspector #627 observed that the home did not have inspection reports from the October 14, 2015, complaint and critical incident inspection (#2015_320612_0020 and #2015_320612_0021) posted in a visible and accessible location in the home.

In an interview with Inspector #681 on June 30, 2017, the ADOC confirmed that that the public inspection reports from the October 14, 2015, complaint and critical incident inspections were not posted and that these reports should be posted. [s. 79. (3) (k)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

In an interview with Inspector #627, the Family Council president stated that the home had not sought the advice of the Family Council in developing and carrying out the satisfaction survey in 2017.

During an interview with the Inspector, the Social Worker (Family Council liaison) stated that they had been informed by the Risk, Quality and Accreditation (RQA) Lead that the home had not sought the advice of the Family Council in developing and carrying out the satisfaction survey for 2017 and it was an oversight. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

In an interview with Inspector #638, resident #023 (Residents' Council chair) stated that they could not recall if the Residents' Council was sought out to review and aid in the development of the satisfaction survey for 2017.

During an interview with the Chaplain (Residents' Council liaison), they stated that they did not believe the satisfaction survey was provided to the Residents' Council for review in 2017. The Chaplain stated that the Residents' Council did receive the survey in 2015 and 2016 to obtain advice in the development and carrying out of the satisfaction survey.

In an interview with Inspector #638, the RQA Lead stated that the Residents' Council was not provided with the satisfaction survey to review in 2017. They stated that the review portion was missed this year and that five new questions had been added to the survey. The RQA Lead stated that they were aware that they were supposed to seek the Residents' Council advise annually regarding the satisfaction survey. [s. 85. (3)]

WN #10: 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 was secured and locked.

Inspector #638 observed the medication cart left unlocked and unattended on a home area on June 23, 2017, at 1150 hours, 1200 hours and 1205 hours, while RPN #109 was administering medications and was not in sight of the cart. During this time the medication cart was left unattended during a meal service with multiple residents, family members and staff within the immediate vicinity of the medication cart. The Inspector also observed resident #016 fidget with the medication cart and drawers while the cart was left unlocked and unattended by RPN #109.

In an interview with Inspector #638, RPN #109 stated that the medication cart was supposed to be locked whenever they were away from the cart. The RPN stated that they may have forgotten to lock the cart on a few occasions during their shift today on June 23, 2017.

Inspector #638 interviewed the DOC, who stated that the medication cart should be locked any time registered staff were not in attendance of the cart. In an interview with the Administrator, they also stated that the medication cart should have been locked to minimize any risk of harm. [s. 129. (1) (a)]

Issued on this 27 day of September 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : RYAN GOODMURPHY (638) - (A1)

Inspection No. / No de l'inspection : 2017_615638_0012 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009430-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Sep 27, 2017;(A1)

Licensee / Titulaire de permis : ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

LTC Home / Foyer de SLD : ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road, SUDBURY, ON, P3E-6L9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Roger Leveille

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, 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: 2016_273638_0020, CO #004;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the care set out in the plan of care is provided to the resident as specified in their plan of care.

The plan shall include, but not limited to;

1. How the licensee will ensure that for every resident in the home, staff will provide care as specified in each resident's plan of care, including the care of residents #015, #018, #020 and #021.

2. How the licensee will ensure that residents' fluids will be thickened to their assessed needs.

The plan must be faxed to the attention of LTCH Inspector Ryan Goodmurphy, at (705) 564-3133. The plan is due on September 15, 2017, and the order is to be complied by October 13, 2017.

Grounds / Motifs :

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

During inspection #2016_273638_0020, compliance order (CO) #004 was served to the licensee on February 9, 2017, related to the provision of care as per the resident's care plan, which ordered the licensee to;
"a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care, including the care of residents #001, #002, #025 and #027.
b) Develop and implement a system to ensure that all front line staff involved in the care of residents in the home, review the residents' plans of care and are kept aware of every residents' most up to date plans of care as changes occur.
c) Provide retraining to all staff (PSWs, RPNs and RNs) involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care and maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed."

While the licensee had complied sections "b and c", section "a", where the licensee was ordered to ensure that every resident in the home was provided with care as specified in their respective plans of care was not complied with.

Inspector #681 observed the lunch meal service in a home area on June 28, 2017. The Inspector observed resident #018 was seated in a specific position while being assisted with their meal.

During a review of resident #018's care plan, the Inspector noted that the resident was supposed to be positioned in the aforementioned position except while at meals. The care plan further identified that the resident required specific directions while eating.

In an interview with Inspector #681, RPN #113 acknowledged that the care plan for resident #018 indicated that they should not be position in the aforementioned position during meal services. The Inspector observed RPN #113 reposition the resident in their seat.

The home's policy titled "Careplanning" last revised December 6, 2016, indicated that the inter-professional team was required to provide care to the resident as it was set out in the plan.

During an interview with Inspector #681, the RD stated that all residents should be

seated at a 90 degree angle during meal services, unless it was otherwise indicated in their care plan. [s. 6. (7)]

2. A complaint was submitted to the Director which alleged that staff were not thickening the residents fluids as per their assessed needs.

a) During the breakfast meal service in a specific home area, Inspector #681 observed three beverages in front of resident #015. One of the thickened fluids appeared too thick and held it's shape on the spoon.

Inspector #681 reviewed resident #015's electronic care plan which indicated that the resident was to receive fluids that were a honey thick consistency.

b) During a lunch meal service in a specific home area, resident #020 told Inspector #681 that they were unable to drink their thickened juice. The resident stated they were not able to drink their fluids because it was too thick and became stuck to the bottom of the cup.

Inspector #681 reviewed resident #020's care plan which indicated that they were supposed to receive fluids that were nectar thick in consistency.

In an interview with the Inspector, PSW #103 stated that they prepared resident #020's thickened fluids for the lunch meal service on the day of the observation, as per the instructions on the beverage cart. The PSW stated that resident #020's fluids appeared to be thicker than a nectar thick consistency.

c) Inspector observed resident #021 during the lunch meal service on another home area. Resident #021 was being fed thickened fluids using a spoon. The fluid was thickened to the point that it was holding the shape of the spoon.

Inspector #681 reviewed resident #021's care plan which indicated that the resident was supposed to receive fluids that were a honey thick consistency.

During an interview with Inspector #681, the FSM provided the Inspector with the following descriptions for thickened fluids:
-Nectar thick: fluid runs freely off the spoon but leaves a thin coating on the spoon, the fluids should pour like most types of fruit nectar.
-Honey thick: fluid slowly drips in dollops off the end of the spoon, the fluids should

pour slowly like liquid honey
-Pudding thick: fluid sits on the spoon and does not flow off, the fluids should be as thick as pudding.

In an interview with Inspector #681 on June 28, 2017, RD # 123 acknowledged that the thickened beverage from resident #015 was pudding thick consistency instead of honey thick consistency. The RD further indicated that there had been an ongoing issue with thickening of fluids and they had completed audits in June 2017.

Inspector #638 reviewed the "Thickened Fluids Audit" completed by the RD on three home areas over a two day period in June 2017. The Inspector identified that the RD noted during the audit that staff did not refer to the "Thicken Up preparation chart" or follow the mixing instructions when thickening fluids. The Inspector further identified that on two of the three home areas audited, staff did not use the proper measuring spoon to thicken their fluids.

During previous inspections (#2015_320612_0020, #2016_264609_0007 and #2016_273638_0020) a Voluntary Plan of Correction (VPC) was issued to the home on November 23, 2015, and a compliance order was served on June 6, 2016, and on February 9, 2017, related to the Long-Term Care Homes Act (LTCHA), 2007, s. 6. (7). The decision to re-issue this compliance order was based on the severity which indicates potential risk of actual harm. The scope was a pattern and a compliance history including an ongoing compliance order issued in this area of the legislation. (681)

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

Nov 24, 2017(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2016_273638_0020, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(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;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall:

1. Ensure that all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

2. Develop and implement a tracking tool to monitor residents exhibiting areas of altered skin integrity, to ensure that every resident exhibiting altered skin integrity receives an assessment at least weekly, if clinically indicated.

Grounds / Motifs :

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

During inspection #2016_273638_0020, compliance order (CO) #002 was served to the licensee on February 9, 2017, related to the provision of care as per the resident's care plan, which ordered the licensee to;
"ensure that all residents at risk of altered skin integrity receive a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital and any other time when a resident is exhibiting altered skin integrity, including pressure ulcers, skin breakdown, skin tears or wounds."

While the licensee had complied with the requirements of CO #002, non-compliance was identified after the compliance date of March 17, 2017.

During an interview with Inspector #627, RN #143 stated that resident #002 had an area of altered skin integrity. Resident #002 was also identified as having an area of altered skin integrity to a specific location through a record review by Inspector #627.

During an interview with Inspector #627, RN #114 stated that resident #002 had an area of altered skin integrity to a specific location and the resident had specific interventions implemented to manage the area of altered skin integrity. The RN stated that a wound assessment should be completed and documented with every dressing change in the electronic progress notes.

Inspector #627 reviewed the home's policy titled "Wound and Skin Care Program" last revised June 2016, which indicated that wounds were to be assessed and documented on a weekly basis. The assessment of a specific type of altered skin integrity was to include: Stage/depth, location, surface area, odour, sinus tracts/undermining/tunneling, exudate, appearance of wound bed, condition of surrounding skin (periwound) and wound edges and assessment of pain.

Inspector #627 reviewed resident #002's electronic records between April 8, 2017, and June 27, 2017. In this review period the Inspector noted that the resident on three occasions went for a period of 14 days, 8 days and 10 days during the review period without a documented wound assessment, although the resident had received dressing changes during those periods.

During an interview with the Inspector, the DOC stated that a wound assessment should be completed at every dressing change and at a minimum a wound assessment should be completed weekly. Inspector #627 reviewed resident #002's electronic record with the DOC who confirmed that resident #002 had not received weekly wound assessments for the above stated periods of time, although they were receiving wound care treatment.

During previous inspections (#2016_264609_0007 and #2016_273638_0020) a compliance order was issued to the home on June 6, 2016, and February 9, 2017, related to Ontario Regulation (O. Reg.) 79/10, s. 50. (2). The decision to re-issue this compliance order was based on the severity which indicates a potential risk of actual harm of the residents of the home exhibiting altered skin integrity. Although the home complied with all the requirements in compliance order #002 of order report #2016_273638_0020, additional non compliance was identified under this area of the legislation during the course of the inspection. (627)

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

Oct 13, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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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 27 day of September 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RYAN GOODMURPHY - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Service Area Office / Bureau régional de services : Sudbury