Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 20, 2015	2015_331595_0006	S-000791-15	Resident Quality Inspection

Licensee/Titulaire de permis

The West Nipissing General Hospital
725 Coursol STURGEON FALLS ON P2B 2Y6

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

THE WEST NIPISSING GENERAL HOSPITAL
725 COURSOL STURGEON FALLS ON P2B 2Y6

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

MARINA MOFFATT (595), SYLVIE LAVICTOIRE (603), VALA MONESTIME BELTER (580)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 7 - 10, 13 - 17, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Chief Nursing Officer, Nurse Managers, Manager of Food Services, Infection Control Practitioner, Activity Coordinator, Education Staff, Registered and Non-Registered Staff, Residents and Family Members.

Throughout the inspection, inspectors observed resident care and home areas, conducted health care record reviews, and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **5 VPC(s)**
- **6 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care that set out clear directions to staff and others who provide direct care to residents #002 and #012.

Inspector #580 reviewed resident #012's plan of care which identified that the resident received routine personal care. Inspector reviewed resident #012's care plan, which did not include these directions for staff.

Inspector #580 spoke with s#-110 who confirmed that the home's plan of care is the care plan in PointClickCare (PCC). Inspector spoke with s#-109 who confirmed that staff get direction related to care from the care plan.

Inspector spoke to s#-103 who confirmed that there was no direction in resident #012's care plan pertaining to the routine care. They explained that staff most likely use their own common sense to provide the care for this resident, and that the care plan should include this direction.

Inspector #580 reviewed resident #002's health care record, including the care plan and progress notes. Contradictions were noted between the care plan and progress notes. The resident's care plan identified that the resident was on isolation, however a progress note dated two days earlier indicated that the isolation precautions would be discontinued that day.

The care plan also identified that the resident was to receive one tub bath per week as per preference, however in another section it stated that the resident does not get up for

baths as per preference and isolation precautions. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in resident #002's plan of care was provided to the resident as specified in the plan.

Inspector #595 reviewed resident #002's health care record which identified that resident #002 used restraints. It was identified that the resident had a wound. The care plan identified that the resident was to be turned and repositioned every two hours by two staff. Inspector spoke with s#-116 and s#-120 who confirmed that the resident was to be repositioned every two hours. S#-119 and s#-120 stated that the resident needed assistance to reposition while in bed. It was also confirmed by s#-109, s#-111, s#-116, s#-119, and s#-120 that the application/removal of a restraint and repositioning are recorded on the Restraint Administration Record. S#-110 stated that the restraint record is the official documentation for restraints and repositioning.

Inspector reviewed the Restraint Administration Record which indicated that on the following days and time frames, resident #002 was not repositioned every two hours:
- April 4, 2015: 0300 - 2400h
- April 5, 2015: 0300 - 1900h
- April 6, 2015: 0300 - 1900h, 2000 - 2400h
- April 7, 2015: 0300 - 1600h, 1700 - 2400h
- April 8, 2015: 0000 - 0200h, 0300 - 1000, 1900 - 2400h
- April 9, 2015: 0000 - 02000h, 0300 - 0700h, 0800 - 1100h, 1800 - 2400h
- April 10, 2015: 0000 - 0700h, 2000 - 2400h
- April 11, 2015: 0000 - 0700h, 0900 - 1300h, 2000 - 2400h
- April 12, 2015: 0000 - 0600h, 2000 - 2400h
- April 13, 2015: 0800 - 12000h
- April 14, 2015: 0300 - 0700h [s. 6. (7)]

3. The licensee failed to ensure that the care set out in resident #012's plan of care was provided to the resident as specified by the plan.

Inspector #595 reviewed resident #012's health care record. The care plan indicated that the resident used restraints. The care plan also identified that staff were to undo and reapply the restraint at least hourly; reposition resident and document in restraint record every hour.

Inspector spoke with s#-109, s#-111, s#-116, s#-119, and s#-120 who confirmed that the

application/removal of a restraint and repositioning are recorded on the Restraint Administration Record. S#-110 stated that the restraint record is the official documentation for restraints and repositioning.

Inspector reviewed the resident's Restraint Administration Record and noted that on the following days and time frames, the resident was not repositioned every hour:

- March 22, 2015: 0800 - 1100, 1700 - 2000h
- March 23, 2015: 0700 - 1000h, 1700 - 2000h
- March 24, 2015: 0700 - 1000h, 1700 - 2100h
- March 25, 2015: 1500 - 1900h
- March 26, 2015: 1500 - 1900h
- April 5, 2015: 0800 - 1200h
- April 7, 2015: 0800 - 1300h
- April 8, 2015: 1700 - 2000h
- April 10, 2015: 1600 - 2000h
- April 13, 2015: 0900 - 1300h [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 care set out in residents #002 and #012's care plans is provided to the resident as specified by the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:

- The Residents' Bill of Rights.
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
- The duty under section 24 to make mandatory reports.
- The protections afforded by section 26.
- The long-term care home's policy to minimize the restraining of residents.

Inspectors #580 and #595 were informed by s#-110 and s#-111 that the home does not

provide training in the areas identified above on orientation for new employees prior to performing their responsibilities.

Inspector #580 reviewed the following home education program and disclosure policies:
- 'Education Opportunities/Professional Development' (Policy No. 200.32)
- 'Education Standards' (Policy No. 200.22)
- 'Disclosure of Wrongdoing' (Policy No. 100.102)
- 'e-Learning Courses – Nursing checklist'

The education program and policies did not include training requirements on orientation for the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and the long-term care home's policy to minimize the restraining of residents. [s. 76. (2)]

2. The licensee failed to ensure that all staff at the home received annual retraining in the following areas:
- The Residents' Bill of Rights;
- The home's policy to promote zero tolerance of abuse and neglect of residents;
- The duty under section 24 to make mandatory reports;
- The protections afforded by section 26;
- The home's policy to minimize the restraining of residents.

Inspectors #580 and #595 were informed by s#-110 and s#-111 that the home does not conduct annual retraining in the areas noted above.

Inspector #580 reviewed the following home education program and disclosure policies:
- 'Education Opportunities/Professional Development' (Policy No. 200.32)
- 'Education Standards' (Policy No. 200.22)
- 'Disclosure of Wrongdoing' (Policy No. 100.102)
- 'e-Learning Courses – Nursing checklist'

The education program and policies did not include annual retraining requirements for the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and the long-term care home's policy to minimize the restraining of residents.

Inspector #580 reviewed the personnel and training file for s#-113. The file did not

include any documented evidence of annual training on the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and the long-term care home's policy to minimize the restraining of residents.

Inspector spoke with s#-109, s#-115, s#-105, s#-118, s#-116, and s#-117 who confirmed that they had never received training on the protections afforded by section 26, and explained that they were not aware that they would be protected when reporting abuse. [s. 76. (4)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the policy 'Continence Care' was complied with.

Inspector #595 reviewed resident #010's health care record which identified that within two months, the resident declined in bowel function (increased bowel incontinence). Inspector #595 spoke with s#-109, s#-116, s#-119, and s#-120 who all reported that the resident had declined in bowel function over the past six months.

Inspector reviewed the home's policy 'Continence Care' (policy no. 605H-16). It identified

that resident's bowel functioning, including routines and the resident's level of continence, were to be reassessed when there were any changes in their health status that affects their continence. Inspector #595 reviewed the completed assessments for resident #010 on PointClickCare (PCC), which included only one Continence Assessment completed two months after the resident's decline in bowel function.

Inspector #595 reviewed the Continence Assessment and noted that it did not accurately assess resident #010's incontinence. Inspector spoke with s#-107 who identified that the Continence Assessment on PCC mainly addressed aspects of urinary incontinence rather than bowel incontinence. They also stated that a bowel assessment is completed using the home's MDS assessment.

Inspector spoke with s#-110 who agreed that the resident did not have a bowel continence assessment when their status changed. S#-110 also identified that the current Continence Assessment does not adequately assess bowel (in)continence and that the resident should have had another assessment in addition to the MDS assessment. S#-110 confirmed that the home does not have a bowel continence assessment and thus, the policy 'Continence Care' was not complied with. [s. 8. (1) (b)]

2. The licensee has failed to ensure that the policy ‘Restraints (Use of)’ is complied with.

Inspector #595 reviewed the policy ‘Restraints (Use of)’ (policy no. 605H-18). The following items were noted under the respective headings:

A. Requirements for restraining with a physical device:
- Resident is released and repositioned once every 2 hours and at any other time based on resident's condition.

B. Resident can only be restrained by a physical device if it is in the care plan and the following conditions are met:
- There is a significant risk that the resident or other person would suffer serious bodily harm if the resident were not restrained.
- Alternatives to the restraining of the resident have been considered, and tried where appropriate, but would not be, or not have been, effective to address the risk.

C. Required documentation:
- What alternatives were considered or tried, and the reasons those alternatives were found to be ineffective.

- Every release and every repositioning including the time. hourly documentation required while resident is restrained (using restraint administration record).

Inspector #595 spoke with s#-110 about the home's policy for restraints. They stated that alternatives to restraints were not documented; the risk to the residents if not restrained would be documented in the consent form; a resident's need for side rails would be based on various assessments, including a fall assessment, if the resident requests the side rails, and what was reported when they come from 'the other side' (indicating the hospital). In contrast, s#-109 reported to the inspector that alternatives to restraints would be documented in the progress notes and the risk to the resident if they were not restrained was not documented.

Inspector spoke with s#-110 about the Restraint Administration Records, who confirmed that this was official documentation. Inspector also spoke with s#116, s#-119 and s#-120 who all stated that the use of a restraint and repositioning would be documented on an hourly-basis in the Restraint Administration Records.

The home's policy indicated that the risk to the resident if not restrained must be identified and documented. Inspector #595 reviewed resident #002's health care record. The risk could not be located in resident #002's care plan, progress notes or on the consent form. Upon further review of the policy, it did not identify how staff are to determine the risk to the resident if they were not restrained.

Inspector #595 reviewed resident #002's care plan and it was identified that the resident used restraints. Inspector reviewed the resident's most recent fall assessment on PCC. According to the assessment, the resident was deemed low risk for falls. However, when the inspector reviewed the resident's signed consent form, it was indicated that the resident was at a high risk for falls (the falls assessment piece was checked off as 'high risk'). Inspector spoke with s#-107 who said that anyone who uses a mechanical lift and/or a wheel chair is deemed a high risk for falls, and since resident #002 used both they were coded as such in the consent form.

Inspector reviewed resident #002's Restraint Administration Records and noted time frames where there was a lack of hourly documentation related to the use of a restraint and repositioning:
- April 12, 2015: 0600 - 1400h
- April 13, 2015: 0000 - 0600h, 1400h - 2200h
- April 15, 2015: 1400h - 2400h

As the time frames on the flow sheets are documented over hourly time frames (i.e. 0100 - 0200h, 0200 – 0300h), the times will be based upon the latest start time, and the earliest end time. For example, if it was documented that a resident was repositioned at 0500 - 0600h, the time starts at 0600h. If it was documented that a resident was repositioned at 1000 - 1100h, the time ends at 1000h. It should also be noted that on the flow sheets, there is an option for staff to document '6' (self-repositioning).

Upon further review of the Restraint Administration Records, it was identified that on the following days and time periods, resident #002 was not repositioned every two hours as identified in the home's policy. Inspector #595 spoke to s#-119 and s#-120 who identified that the resident cannot move on his own in bed and required staff assistance. As a result, Inspector reviewed documentation for night shift as well. The time frames reflect a lack of repositioning every two hours:
- April 4, 2015: 0300 - 2400h
- April 5, 2015: 0300 - 1900h
- April 6, 2015: 0300 - 1900h, 2000 - 2400h (carries to next day)
- April 7, 2015: 0000 - 0200h, 0300 - 1600h, 1700 - 2400h (carries to next day)
- April 8, 2015: 0000 - 0200h, 0300 - 1000, 1900 - 2400h (carries to next day)
- April 9, 2015: 0000 - 02000h, 0300 - 0700h, 0800 - 1100h, 1800 - 2400h (carries to next day)
- April 10, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- April 11, 2015: 0000 - 0700h, 0900 - 1300h, 2000 - 2400h (carries to next day)
- April 12, 2015: 0000 - 0600h, 2000 - 2400h
- April 13, 2015: 0800 - 12000h
- April 14, 2015: 0300 - 0700h

Inspector reviewed resident #012's care plan, which indicated that the resident used restraints. Inspector reviewed the Restraint Administration Records for resident #012. On the following days and shifts there was no hourly documentation related to the use of a restraint and repositioning:
- April 9, 2015: 1400 - 2400h
- April 10, 2015: 0000 - 0600h

Upon further review of the Restraint Administration Records, it was identified that on the following days and time periods, the resident was not repositioned either as per policy (every two hours) or as per the resident's care plan (every hour). Because there was no indication in the care plan of the resident's ability to independently move in bed, all times

of the day were reviewed by Inspector #595 for repositioning:
- March 21, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- March 22, 2015: 0000 - 0700h, 0800 - 1100h, 1700 - 2000h, 2100 - 2400h (carries to next day)
- March 23, 2015: 0000 - 0600h, 0700 - 1000h, 1700 - 2000h, 2100 - 2400h (carries to next day)
- March 24, 2015: 0000 - 0600h, 0700 - 1000h, 1700 - 2100h, 2200 - 2400h (carries to next day)
- March 25, 2015: 0000 - 0600h, 1500 - 1900h, 2000 - 2400h (carries to next day)
- March 26, 2015: 0000 - 0600h, 1500 - 1900h, 2000 - 2400h
- April 2, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- April 3, 2015: 0000 - 0200h, 0300 - 0600h, 2100 - 2400h (carries to next day)
- April 4, 2015; 0000 - 0200h, 0300 - 0600h, 2100 - 2400h (carries to next day)
- April 5, 2015: 0000 - 0200h, 0300 - 0700h, 0800 - 1200h, 2000 - 2300h
- April 6, 2015: 0300 - 0600h, 2000 - 2400h (carries to next day)
- April 7, 2015: 0000 - 0200h, 0300 - 0700h, 0800 - 1300h, 2000 - 2400h (carries to next day)
- April 8, 2015: 0000 - 0200h, 0300 - 0800h, 1700 - 2000h, 2100 - 2400h (carries to next day)
- April 9, 2015: 0000 - 0200h, 0300 - 0600h
- April 10, 2015: 1600 - 2000h, 2100h - 2400h (carries to next day)
- April 11, 2015: 0000 - 0700h, 2100 - 2400h (carries to next day)
- April 12, 2015; 0000 - 0700h, 2100h - 2400h (carries to next day)
- April 13, 2015; 0000 - 0700h, 0900 - 1300h, 2100 - 2400h (carries to next day)
- April 14, 2015: 0000 - 0200h, 0300 - 0700h, 1900 - 2400h (carries to next day)
- April 15, 2015: 0000 - 0300h

Inspector #595 reviewed the care plan for resident #010 which identified that the resident used four bed rails while in bed, and a lap tray while in their wheelchair. Inspector reviewed the Restraint Administration Records for resident #010. On the following days and shifts there was no hourly documentation related to the use of a restraint and repositioning:
- April 8, 2015: 0600 - 1400h
- April 13, 2015: 0600 - 2200h
- April 14, 2015: 0600 - 1400h
- April 15, 2015: 1400 - 2400h

Upon further review of the Restraint Administration Records, it was identified that on the

following days and time frames resident #010 was not repositioned as per policy (every two hours). As there was no indication of the resident's ability to independently move in bed in the care plan, all times of the day were checked for repositioning:
- March 24, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- March 25, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- March 26, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- March 27, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- March 28, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- March 29, 2015: 0000 - 0700h, 2000 - 2400h
- April 8, 2015: 1800 - 2400h
- April 9, 2015: 0300 - 0700, 2100 - 2400h (carries to next day)
- April 10, 2015: 0000 - 0700h, 1400 - 2400h (carries to next day)
- April 11, 2015: 0000 - 0800h, 1300 - 2400h (carries to next day)
- April 12, 2015: 0000 - 0600h, 1300 - 2400h (carries to next day)
- April 13, 2015: 0000 - 1300h, 1400 - 1800h, 2000 - 2400h
- April 14, 2015: 2100 - 2400h (carries to next day)
- April 15, 2015: 0000 - 0200h, 0300 - 0700h [s. 8. (1) (b)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #603 observed bed rails up on the beds of residents' #002, #010 and #012.

Inspector #595 spoke with s#-109 and s#-111 who both stated that the home does not assess/evaluate entrapment zones. S#-111 directed Inspector #595 to speak with s#-110. This staff member was not able to tell the inspector if the home completed entrapment assessments where bed rails are used, and she then spoke with the Manager of Maintenance and Housekeeping, s#-112. It was confirmed by s#-112 that entrapment zones are not assessed/evaluated. [s. 15. (1) (b)]

2. The licensee failed to ensure that where bed rails are used, height and latch reliability are addressed as other safety measures.

Inspector #603 observed bed rails up on the beds of residents' #002, #010 and #012.

Inspector #595 spoke with s#-109 and s#-111 who both stated that the home does not assess/evaluate height and latch reliability. Inspector #595 also spoke with s#-110 who stated that they would check with the Manager of Maintenance and Housekeeping, s#-112, if height and latch reliability were assessed. S#-112 informed s#-110 that the home checks height and latch reliability, however there is no documentation or record of this process. [s. 15. (1) (c)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the program includes the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends.

During stage one of the Resident Quality Inspection, Inspector #603 spoke with three residents who identified concerns with the home's availability of recreation and social activities. Inspector #603 interviewed resident #002 who explained that there were no recreation and social activities being offered on a daily basis; there were no activities being offered in the evenings and very little activities were offered during the weekend. The resident also explained that they had not received any recreation or social activities for a period of time due to being on isolation precautions.

Inspector #603 interviewed residents #004 and #008 who explained that there were no recreation and social activities being offered in the evenings and very little activities were offered during the weekend.

Inspector #603 reviewed the activity calendars for the month of February, March, and April, 2015 and noted that there were no scheduled activities in the evenings and on Sundays.

On April 10, 2015, Inspector #603 interviewed s#-106 who explained that there are only 26 hours per week dedicated to recreation and social activities. They explained that typically there are no activities offered on Sundays and most Mondays, that there are only two Saturdays per month that have scheduled activities and there are no activities offered in the evenings. [s. 65. (2) (b)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that: a) a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and their SDM, within six weeks of the admission of the resident, and at least annually after that; b) the resident, their SDM is invited to participate in these care conferences; and c) a record is kept of the date, the participants, and the results of the conference.

Inspector #603 interviewed s#-103 who explained that the home completes a care conference within three months of admission and then yearly. The conference usually involves the resident, staff, and SDM. Inspector #603 reviewed the home's policy 'Resident Care Plan' (policy no. 605H-12) which indicated that the resident's representatives are offered the opportunity to participate in the team conference.

Inspector #603 reviewed the home's 'Resident Orientation to Interim Long-Term Care' and it was identified that a care conference was to be done post admission and annually, however did not specify within six weeks of admission, and at least yearly after that.

Inspector #603 reviewed resident #005's 'LTC Interdisciplinary Care Conference' form which indicated that the Care Conference was completed until 11 weeks after admission. [s. 27. (1)]

2. Inspector #580 interviewed resident #006's Substitute Decision Maker (SDM) who identified that they were not invited to the care conference to discuss the resident's plan of care on admission or at any other time.

Inspector #603 reviewed resident #006's 'LTC Interdisciplinary Care Conference' form which indicated that the Care Conference was completed 22 weeks after admission, and there was no record of who participated and the results of the conference. [s. 27. (1)]

3. Inspector #580 interviewed resident #007's SDM who explained that they were not invited to any care conference to discuss the resident's plan of care on admission or at any other time.

Inspector #603 reviewed resident #007's 'LTC Interdisciplinary Care Conference' form which did not have a record of who participated and the results of the conference. [s. 27. (1)]

4. Inspector #580 reviewed resident #009's 'LTC Interdisciplinary Care Conference' form and could not locate any documentation indicating that a care conference was held within six weeks following the resident’s admission. At the time of the inspection, s#-110 and s#-107 confirmed to the inspector that no admission care conference had been held for resident #009. [s. 27. (1)]

5. Inspector #580 reviewed resident #012's 'LTC Interdisciplinary Care Conference' form and could not locate any documentation indicating that a care conference was held within six weeks following the resident’s admission. At the time of the inspection, s#-110 and s#-107 confirmed to the inspector that no admission care conference had been held for resident #009. [s. 27. (1)]

6. Inspector #580 reviewed resident #013's 'LTC Interdisciplinary Care Conference' form and could not locate any documentation indicating that a care conference was held annually since the resident’s admission. Inspector spoke with s#-110 and s#-107 who confirmed that an annual care conference had not been held for resident #013. [s. 27. (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 care conference of the interdisciplinary team is held within six weeks of the resident's admission and annually; the resident's SDM is invited to participate; and a record of the care conference is kept of the date, the participants and the results of the conference, to be implemented voluntarily.

WN #7: 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 failed to ensure that resident #002's restraint was included in the care plan.

On April 8, 2015 Inspector #603 observed bed rails up on resident #002's bed. Inspector #595 reviewed the resident's health care record. A signed consent and a physician's order were located. Upon review of the care plan, the inspector could not locate the use of bed rails. Inspector #595 spoke with s#-107 who stated that the use of a restraint or bed rails should be in the resident's care plan. S#-107 reviewed resident #002's care plan and confirmed that the use of bed rails was not identified. The staff member then added this information to the resident's care plan. [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 any restraint used by a resident, including resident #002, is included in the plan of care, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 79. (1) Every licensee of a long-term care home shall ensure that the required information is posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. 2007, c. 8, s. 79. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an explanation of the protections afforded under section 26 of the LTCHA, 2007 are posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations.

A tour of the home was completed and Inspector #580 did not observe posted information pertaining to whistle-blowing protection. Inspector spoke with s#-109, s#-115, s#-105, s#-118, s#-116, and s#-117 who confirmed that they had never heard of whistleblowing protection and did not know that they would be protected when reporting abuse. S#-110 confirmed to the inspector that the home does not have a whistle-blowing protection policy. [s. 79. (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 an explanation of the protections afforded under section 26 of the LTCHA, 2007 is posted in the home in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #008, who self-administered a drug, was authorized to do so by a physician.

On April 13, 2015, resident #008 confirmed to Inspector #580 that they kept a specific medication at their bedside, that they take it "at my own time". The inspector observed the medication device on the resident's night table, and inside the night table drawer, observed a box of labelled medication. The prescribing doctor could not be located on the label.

Inspector #595 spoke with s#-113 who confirmed that resident #008 kept the medication at the bedside. Inspector asked if there was a physician's order for this medication. S#-113 and s#-110 stated that the order for this would be in the physician's orders in the resident's health care record. Inspector #595 reviewed resident #008's health care record and could not locate an order for the bedside medication. The missing order was confirmed by s#-110 and s#-113. [s. 131. (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 a physician's order is obtained for any residents, including resident #008, who have medications at the bedside, to be implemented voluntarily.

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:
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:
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #002 was treated with respect, and in a way that fully respected the resident's dignity.

On April 8, 2015 at approximately 1050h, Inspector #580 walked past the home's lounge. The lounge had a large window that faced a hallway where residents and visitors walk to resident rooms and the nursing station. Two PSWs were observed to use a mechanical lift to move resident #002 from a stretcher to a wheelchair. The resident was dressed in a hospital gown and their buttocks and perineal area were exposed to the hallway. Inspector observed housekeeping staff nearby, visitors in the room next door, and residents in the hallway. The resident's family member was in the lounge as well, however was not able to see the exposed area because they were at the resident's shoulder level. The resident did not appear to be aware of the exposure.

Inspector spoke with the two staff members about this, s#-105 and s#-100, who stated that the resident was normally transferred in their room, however the resident's room was being cleaned at that time and could not be used. Inspector spoke with s#-103 who stated that this had never occurred before. S#-104 stated that this did not usually occur and perhaps the room needed privacy curtains.

Later that day, Inspector #603 spoke with resident #002 about the incident that occurred earlier. The resident stated that they felt it was simply uncomfortable and would have

preferred staying in their room.

On April 16, 2015 Inspector #580 spoke with s#-105 again about the incident. The staff member explained that they did not realize that the resident's perineal area and buttocks were exposed when they used the mechanical lift to move the resident from the stretcher to the wheelchair. S#-105 explained to the inspector that when resident #002 was undressed and dressed, there was usually additional staff standing in the hallway to protect the resident from exposure. They continued to explain that at the time of this transfer from stretcher to wheelchair, there was no additional staff available as they had left for lunch. [s. 3. (1) 1.]

2. The licensee failed to ensure that resident #002 was able to pursue social, cultural, religious, spiritual and other interests and develop their potential.

On April 9, 2015, Inspector #603 interviewed resident #002 who explained that they had not been able to participate or receive any recreation or social activities for a period of time due to being on isolation precautions. Inspector #603 reviewed resident #002's health care record which indicated that the resident was on isolation precautions.

Inspector #603 reviewed resident #002's LTC Resident Attendance Record for the months of January, February, March, and April 2015. The following activities were documented as provided by staff: one movie on January 15, 2015; one visit on February 18, 2015; one visit on March 3, 2015 and one card playing on April 10, 2015.

Inspector #603 interviewed s#-106 who confirmed that resident #002 did not receive any recreation or social activities for a recent period of time as they were on isolation precautions. S#-106 explained that if a resident was unable to leave their room, the staff would try and do activities such as reading, offering magazines, foot massages, or one to one visits. The staff member continued to explain that none of these activities were provided to resident #002 while they were on isolation because there was not enough hours, man power, or volunteers to tend to the resident who was confined to their room. [s. 3. (1) 23.]

WN #11: 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,
(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; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 received a skin assessment upon return from the hospital.

Inspector #595 reviewed the health care record for resident #006. It was identified that the resident had been admitted to the hospital and then returned to the home. Inspector reviewed the completed assessments in PointClickCare (PCC) which did not include a skin assessment after the resident's return to the home.

Inspector spoke with s#-109 who confirmed that staff are to complete a skin assessment upon a resident's return from the hospital. This staff member also confirmed that resident #006 did not receive a skin assessment when they returned from the hospital. [s. 50. (2) (a) (ii)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the weekly menus were communicated to the residents.

On April 7, 2015 Inspector #603 observed the dining service between 1145h to 1300h. Inspector observed the posted 3-week menu schedule which identified 'Fall and Winter 2013 - week 3 (service for week 10-28-13)'. There was also a posting for 'Today's menu' and one for 'Tomorrow's menu', which both referred to the weekly schedule of 2013.

Inspector #603 interviewed s#-101 who explained that the posted weekly menus will not change until the Spring and Summer schedule. The home does not change the dates as the menus remain the same every 3 weeks. [s. 73. (1) 1.]

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARINA MOFFATT (595), SYLVIE LAVICTOIRE (603), VALA MONESTIME BELTER (580)
Inspection No. / No de l'inspection :	2015_331595_0006
Log No. / Registre no:	S-000791-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 20, 2015
Licensee / Titulaire de permis :	The West Nipissing General Hospital 725 Coursol, STURGEON FALLS, ON, P2B-2Y6
LTC Home / Foyer de SLD :	THE WEST NIPISSING GENERAL HOSPITAL 725 COURSOL, STURGEON FALLS, ON, P2B-2Y6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cynthia Desormiers

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

Order / Ordre :

The licensee shall ensure that there is a written plan of care for residents #002 and #012 that sets out clear directions to staff and others who provide direct care to the residents.

Grounds / Motifs :

1. During a previous inspection, #2014_283544_0019, a VPC was issued under s. 6 (1) (c).

1. The licensee failed to ensure that there was a written plan of care that set out clear directions to staff and others who provide direct care to residents #002 and #012.

Inspector #580 reviewed resident #012's plan of care which identified that the resident received routine personal care. Inspector reviewed resident #012's care plan, which did not include these directions for staff.

Inspector #580 spoke with s#-110 who confirmed that the home's plan of care is the care plan in PointClickCare (PCC). Inspector spoke with s#-109 who confirmed that staff get direction related to care from the care plan.

Inspector spoke to s#-103 who confirmed that there was no direction in resident #012's care plan pertaining to the routine care. They explained that staff most likely use their own common sense to provide the care for this resident, and that the care plan should include this direction.

Inspector #580 reviewed resident #002's health care record, including the care plan and progress notes. Contradictions were noted between the care plan and progress notes. The resident's care plan identified that the resident was on isolation, however a progress note dated two days earlier indicated that the isolation precautions would be discontinued that day.

The care plan also identified that the resident was to receive one tub bath per week as per preference, however in another section it stated that the resident does not get up for baths as per preference and isolation precautions. (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 29, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, c. 8, s. 76 (2).

The plan must include:

(1) The home's plan related to how new staff will be trained in the following prior to performing their responsibilities:
- The Residents' Bill of Rights;
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
- The duty under section 24 to make mandatory reports;
- The protections afforded by section 26; and
- The long-term care home's policy to minimize the restraining of residents.

(2) Timelines for training completion for any new employees.

(3) A process to track completion of training for staff prior to performing their responsibilities.

(4) How the training will be provided (i.e. online learning, class room, etc).

(5) Process to update relevant policies to address training and orientation requirements.

This plan must be faxed, to the attention of LTCHI Marina Moffatt, at (705) 564-3133. This plan is due on June 5, 2015 with a compliance date of July 31, 2015.

Grounds / Motifs :

1. 1. The licensee failed to ensure that no staff at the home performs their responsibilities before receiving training in the areas mentioned below:

- The Residents' Bill of Rights.
- The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
- The duty under section 24 to make mandatory reports.
- The protections afforded by section 26.
- The long-term care home's policy to minimize the restraining of residents.

Inspectors #580 and #595 were informed by s#-110 and s#-111 that the home does not provide training in the areas identified above on orientation for new employees prior to performing their responsibilities.

Inspector #580 reviewed the following home education program and disclosure policies:
- 'Education Opportunities/Professional Development' (Policy No. 200.32)
- 'Education Standards' (Policy No. 200.22)
- 'Disclosure of Wrongdoing' (Policy No. 100.102)
- 'e-Learning Courses – Nursing checklist'

The education program and policies did not include training requirements on orientation for the Residents' Bill of Rights; the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and the long-term care home's policy to minimize the restraining of residents. (580)

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, c. 8, s. 76 (4).

The plan must include:

(1) A timeline for when all staff training (including those staff currently employed) will be completed in the following areas:
- The Residents' Bill of Rights;
- The home's policy to promote zero tolerance of abuse and neglect of residents;
- The duty under section 24 to make mandatory reports;
- The protections afforded by section 26;
- The home's policy to minimize the restraining of residents.

(2) The home's schedule for annual retraining on the above areas.

(3) A process to track completion of annual retraining.

(4) How the retraining will be provided (i.e. online learning, class room, etc).

(5) Process to update relevant policies to address annual retraining.

This plan must be faxed, to the attention of LTCHI Marina Moffatt, at (705) 564-3133. This plan is due on June 5, 2015 with a compliance date of August 28, 2015.

Grounds / Motifs :

1. 1. The licensee failed to ensure that all staff at the home received annual retraining in the following areas:
- The Residents' Bill of Rights;
- The home's policy to promote zero tolerance of abuse and neglect of residents;

- The duty under section 24 to make mandatory reports;
- The protections afforded by section 26;
- The home's policy to minimize the restraining of residents.

Inspectors #580 and #595 were informed by s#-110 and s#-111 that the home does not conduct annual retraining in the areas noted above.

Inspector #580 reviewed the following home education program and disclosure policies:
- 'Education Opportunities/Professional Development' (Policy No. 200.32)
- 'Education Standards' (Policy No. 200.22)
- 'Disclosure of Wrongdoing' (Policy No. 100.102)
- 'e-Learning Courses – Nursing checklist'

The education program and policies did not include annual retraining requirements for the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and the long-term care home's policy to minimize the restraining of residents.

Inspector #580 reviewed the personnel and training file for s#-113. The file did not include any documented evidence of annual training on the home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and the long-term care home's policy to minimize the restraining of residents.

Inspector spoke with s#-109, s#-115, s#-105, s#-118, s#-116, and s#-117 who confirmed that they had never received training on the protections afforded by section 26, and explained that they were not aware that they would be protected when reporting abuse. (580)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 28, 2015

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the policies 'Continence Care' (policy no. 605H-16) and 'Restraints (Use of)' (policy no. 605H-18) are complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the policy 'Restraints (Use of)' is complied with.

Inspector #595 reviewed the policy 'Restraints (Use of)' (policy no. 605H-18). The following items were noted under the respective headings:

A. Requirements for restraining with a physical device:
- Resident is released and repositioned once every 2 hours and at any other time based on resident's condition.

B. Resident can only be restrained by a physical device if it is in the care plan and the following conditions are met:
- There is a significant risk that the resident or other person would suffer serious bodily harm if the resident were not restrained.
- Alternatives to the restraining of the resident have been considered, and tried where appropriate, but would not be, or not have been, effective to address the risk.

C. Required documentation:

- What alternatives were considered or tried, and the reasons those alternatives were found to be ineffective.
- Every release and every repositioning including the time. hourly documentation required while resident is restrained (using restraint administration record).

Inspector #595 spoke with s#-110 about the home's policy for restraints. They stated that alternatives to restraints were not documented; the risk to the residents if not restrained would be documented in the consent form; a resident's need for side rails would be based on various assessments, including a fall assessment, if the resident requests the side rails, and what was reported when they come from 'the other side' (indicating the hospital). In contrast, s#-109 reported to the inspector that alternatives to restraints would be documented in the progress notes and the risk to the resident if they were not restrained was not documented.

Inspector spoke with s#-110 about the Restraint Administration Records, who confirmed that this was official documentation. Inspector also spoke with s#116, s#-119 and s#-120 who all stated that the use of a restraint and repositioning would be documented on an hourly-basis in the Restraint Administration Records.

The home's policy indicated that the risk to the resident if not restrained must be identified and documented. Inspector #595 reviewed resident #002's health care record. The risk could not be located in resident #002's care plan, progress notes or on the consent form. Upon further review of the policy, it did not identify how staff are to determine the risk to the resident if they were not restrained.

Inspector #595 reviewed resident #002's care plan and it was identified that the resident used restraints. Inspector reviewed the resident's most recent fall assessment on PCC. According to the assessment, the resident was deemed low risk for falls. However, when the inspector reviewed the resident's signed consent form, it was indicated that the resident was at a high risk for falls (the falls assessment piece was checked off as 'high risk'). Inspector spoke with s#-107 who said that anyone who uses a mechanical lift and/or a wheel chair is deemed a high risk for falls, and since resident #002 used both they were coded as such in the consent form.

Inspector reviewed resident #002's Restraint Administration Records and noted

time frames where there was a lack of hourly documentation related to the use of a restraint and repositioning:
- April 12, 2015: 0600 - 1400h
- April 13, 2015: 0000 - 0600h, 1400h - 2200h
- April 15, 2015: 1400h - 2400h

As the time frames on the flow sheets are documented over hourly time frames (i.e. 0100 - 0200h, 0200 – 0300h), the times will be based upon the latest start time, and the earliest end time. For example, if it was documented that a resident was repositioned at 0500 - 0600h, the time starts at 0600h. If it was documented that a resident was repositioned at 1000 - 1100h, the time ends at 1000h. It should also be noted that on the flow sheets, there is an option for staff to document '6' (self-repositioning).

Upon further review of the Restraint Administration Records, it was identified that on the following days and time periods, resident #002 was not repositioned every two hours as identified in the home's policy. Inspector #595 spoke to s#-119 and s#-120 who identified that the resident cannot move on his own in bed and required staff assistance. As a result, Inspector reviewed documentation for night shift as well. The time frames reflect a lack of repositioning every two hours:
- April 4, 2015: 0300 - 2400h
- April 5, 2015: 0300 - 1900h
- April 6, 2015: 0300 - 1900h, 2000 - 2400h (carries to next day)
- April 7, 2015: 0000 - 0200h, 0300 - 1600h, 1700 - 2400h (carries to next day)
- April 8, 2015: 0000 - 0200h, 0300 - 1000, 1900 - 2400h (carries to next day)
- April 9, 2015: 0000 - 02000h, 0300 - 0700h, 0800 - 1100h, 1800 - 2400h (carries to next day)
- April 10, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- April 11, 2015: 0000 - 0700h, 0900 - 1300h, 2000 - 2400h (carries to next day)
- April 12, 2015: 0000 - 0600h, 2000 - 2400h
- April 13, 2015: 0800 - 12000h
- April 14, 2015: 0300 - 0700h

Inspector reviewed resident #012's care plan, which indicated that the resident used restraints. Inspector reviewed the Restraint Administration Records for resident #012. On the following days and shifts there was no hourly documentation related to the use of a restraint and repositioning:
- April 9, 2015: 1400 - 2400h

- April 10, 2015: 0000 - 0600h

Upon further review of the Restraint Administration Records, it was identified that on the following days and time periods, the resident was not repositioned either as per policy (every two hours) or as per the resident's care plan (every hour). Because there was no indication in the care plan of the resident's ability to independently move in bed, all times of the day were reviewed by Inspector #595 for repositioning:
- March 21, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- March 22, 2015: 0000 - 0700h, 0800 - 1100h, 1700 - 2000h, 2100 - 2400h (carries to next day)
- March 23, 2015: 0000 - 0600h, 0700 - 1000h, 1700 - 2000h, 2100 - 2400h (carries to next day)
- March 24, 2015: 0000 - 0600h, 0700 - 1000h, 1700 - 2100h, 2200 - 2400h (carries to next day)
- March 25, 2015: 0000 - 0600h, 1500 - 1900h, 2000 - 2400h (carries to next day)
- March 26, 2015: 0000 - 0600h, 1500 - 1900h, 2000 - 2400h
- April 2, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- April 3, 2015: 0000 - 0200h, 0300 - 0600h, 2100 - 2400h (carries to next day)
- April 4, 2015; 0000 - 0200h, 0300 - 0600h, 2100 - 2400h (carries to next day)
- April 5, 2015: 0000 - 0200h, 0300 - 0700h, 0800 - 1200h, 2000 - 2300h
- April 6, 2015: 0300 - 0600h, 2000 - 2400h (carries to next day)
- April 7, 2015: 0000 - 0200h, 0300 - 0700h, 0800 - 1300h, 2000 - 2400h (carries to next day)
- April 8, 2015: 0000 - 0200h, 0300 - 0800h, 1700 - 2000h, 2100 - 2400h (carries to next day)
- April 9, 2015: 0000 - 0200h, 0300 - 0600h
- April 10, 2015: 1600 - 2000h, 2100h - 2400h (carries to next day)
- April 11, 2015: 0000 - 0700h, 2100 - 2400h (carries to next day)
- April 12, 2015; 0000 - 0700h, 2100h - 2400h (carries to next day)
- April 13, 2015; 0000 - 0700h, 0900 - 1300h, 2100 - 2400h (carries to next day)
- April 14, 2015: 0000 - 0200h, 0300 - 0700h, 1900 - 2400h (carries to next day)
- April 15, 2015: 0000 - 0300h

Inspector #595 reviewed the care plan for resident #010 which identified that the resident used four bed rails while in bed, and a lap tray while in their wheelchair. Inspector reviewed the Restraint Administration Records for resident #010. On the following days and shifts there was no hourly documentation related to the

use of a restraint and repositioning:
- April 8, 2015: 0600 - 1400h
- April 13, 2015: 0600 - 2200h
- April 14, 2015: 0600 - 1400h
- April 15, 2015: 1400 - 2400h

Upon further review of the Restraint Administration Records, it was identified that on the following days and time frames resident #010 was not repositioned as per policy (every two hours). As there was no indication of the resident's ability to independently move in bed in the care plan, all times of the day were checked for repositioning:
- March 24, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- March 25, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- March 26, 2015: 0000 - 0600h, 2100 - 2400h (carries to next day)
- March 27, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- March 28, 2015: 0000 - 0700h, 2000 - 2400h (carries to next day)
- March 29, 2015: 0000 - 0700h, 2000 - 2400h
- April 8, 2015: 1800 - 2400h
- April 9, 2015: 0300 - 0700, 2100 - 2400h (carries to next day)
- April 10, 2015: 0000 - 0700h, 1400 - 2400h (carries to next day)
- April 11, 2015: 0000 - 0800h, 1300 - 2400h (carries to next day)
- April 12, 2015: 0000 - 0600h, 1300 - 2400h (carries to next day)
- April 13, 2015: 0000 - 1300h, 1400 - 1800h, 2000 - 2400h
- April 14, 2015: 2100 - 2400h (carries to next day)
- April 15, 2015: 0000 - 0200h, 0300 - 0700h (595)

2. The licensee failed to ensure that the policy 'Continence Care' was complied with.

Inspector #595 reviewed resident #010's health care record which identified that within two months, the resident declined in bowel function (increased bowel incontinence). Inspector #595 spoke with s#-109, s#-116, s#-119, and s#-120 who all reported that the resident had declined in bowel function over the past six months.

Inspector reviewed the home's policy 'Continence Care' (policy no. 605H-16). It identified that resident's bowel functioning, including routines and the resident's level of continence, were to be reassessed when there were any changes in their health status that affects their continence. Inspector #595 reviewed the

completed assessments for resident #010 on PointClickCare (PCC), which included only one Continence Assessment completed two months after the resident's decline in bowel function.

Inspector #595 reviewed the Continence Assessment and noted that it did not accurately assess resident #010's incontinence. Inspector spoke with s#-107 who identified that the Continence Assessment on PCC mainly addressed aspects of urinary incontinence rather than bowel incontinence. They also stated that a bowel assessment is completed using the home's MDS assessment.

Inspector spoke with s#-110 who agreed that the resident did not have a bowel continence assessment when their status changed. S#-110 also identified that the current Continence Assessment does not adequately assess bowel (in) continence and that the resident should have had another assessment in addition to the MDS assessment. S#-110 confirmed that the home does not have a bowel continence assessment and thus, the policy 'Continence Care' was not complied with. (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 19, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, and other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Inspector #603 observed bed rails up on the beds of residents' #002, #010 and #012.

Inspector #595 spoke with s#-109 and s#-111 who both stated that the home does not assess/evaluate entrapment zones. S#-111 directed Inspector #595 to speak with s#-110. This staff member was not able to tell the inspector if the home completed entrapment assessments where bed rails are used, and she then spoke with the Manager of Maintenance and Housekeeping, s#-112. It was confirmed by s#-112 that entrapment zones are not assessed/evaluated. (595)

2. The licensee failed to ensure that where bed rails are used, height and latch reliability are addressed as other safety measures.

Inspector #603 observed bed rails up on the beds of residents' #002, #010 and #012.

Inspector #595 spoke with s#-109 and s#-111 who both stated that the home does not assess/evaluate height and latch reliability. Inspector #595 also spoke with s#-110 who stated that they would check with the Manager of Maintenance and Housekeeping, s#-112, if height and latch reliability were assessed. S#-112 informed s#-110 that the home checks height and latch reliability, however there is no documentation or record of this process. (595)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program;
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends;
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests;
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities;
(e) the provision of information to residents about community activities that may be of interest to them; and
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 65 (2).

The plan must include:

(1) A staffing schedule which ensures that recreation and social activities are offered on days, evenings and weekends.

(2) How activities will be provided to residents on isolation precautions.

(3) A schedule for the next three months (June, July, August) that identifies what activities will be offered on days, evenings and weekends. These activities will include recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests.

(4) A process to track whether activities were offered and/or provided to residents.

The plan must be faxed, to the attention of LTCH Inspector Marina Moffatt, at (705)-564-3133. The plan is due on June 5, 2015 with a compliance date of July 3, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that the program includes the development and implementation of a schedule of recreation and social activities that are offered during days, evenings and weekends.

During stage one of the Resident Quality Inspection, Inspector #603 spoke with three residents who identified concerns with the home's availability of recreation and social activities. Inspector #603 interviewed resident #002 who explained that there were no recreation and social activities being offered on a daily basis; there were no activities being offered in the evenings and very little activities were offered during the weekend. The resident also explained that they had not received any recreation or social activities for a period of time due to being on isolation precautions.

Inspector #603 interviewed residents #004 and #008 who explained that there were no recreation and social activities being offered in the evenings and very little activities were offered during the weekend.

Inspector #603 reviewed the activity calendars for the month of February, March, and April, 2015 and noted that there were no scheduled activities in the evenings and on Sundays.

On April 10, 2015, Inspector #603 interviewed s#-106 who explained that there are only 26 hours per week dedicated to recreation and social activities. They explained that typically there are no activities offered on Sundays and most Mondays, that there are only two Saturdays per month that have scheduled activities and there are no activities offered in the evenings. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 03, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 20th day of May, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Marina Moffatt

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