Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 31, 2016	2016_269627_0006	033553-15	Follow up

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

SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 9, 10, 2016.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Officer, Registered Nurses (RNs), Personal Support Workers (PSWs) and a Speech Pathologist.

The Inspector also reviewed various policies, plans of care and other documentation within the home, conducted a daily walk through the care areas, observed staff to resident interactions and the delivery of care and services to the residents.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Personal Support Services
Training and Orientation

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #002	2015_320612_0018	627
O.Reg 79/10 s. 8. (1)	CO #003	2015_320612_0018	627

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

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

Resident #002 was observed in the dining room with an adaptive device for meals. PSW #101 was observed feeding the resident a specific way. The resident was also observed not wearing glasses.

During another meal, resident #002 was observed in the dining room with an adaptive device for meals. PSW #103 was observed feeding the resident in a specific way. The resident was again observed not wearing glasses.

A review of the care plan indicated interventions related to assisting the resident with eating which directed the staff to assist the resident in a specified way (which was not what the inspector had observed) and that the resident had a specified adaptive device (which was not what the inspector had observed the resident using) for their meals. According to the same care plan, interventions related to the resident's inability to focus on objects included: "Ensure eyeglasses are clean, appropriate and being worn by resident".

During an interview, the Speech Pathologist stated to the Inspector that they were not aware of any choking risks or interventions for preventing choking for resident #002.

During an interview, PSW #101 stated resident #002 no longer used adaptive tools for

eating. They had trialed them and the resident did not like using them. They further stated that resident #002 had never worn glasses.

During an interview, PSW #103 stated resident #002 had trialed adaptive tools but they would not use them therefore, they were discontinued. As well, PSW #103 stated the resident didn't wear glasses. This was further confirmed by another PSW sitting at the next table.

During an interview, PSW #102 and #103 stated to the Inspector that if they had questions regarding the care of a resident, they would ask the charge RN or RPN. They further indicated that changes to a resident's plan of care were discussed during report at the beginning of the shift. PSW #102 and #103 were unsure where interventions for the focus of eating were listed in the resident's plan of care when requested by the Inspector, and PSW #102 was unable to find the interventions for eating when provided with the resident's care plan. PSW #103 further stated they had never been directed to use the care plans during their orientation.

During an interview, the Chief Nursing Officer confirmed to the Inspector that the plan of care did not set out clear direction to staff and others who provided direct care to the resident.

The licensee was previously ordered during inspection 2015_320612_0018 to complete a thorough review of resident #002's plan of care to ensure that the planned care was reviewed and updated, set out clear direction to staff and others who provided direct care and that education was provided to all staff related to plan of care development and implementation. Given that resident #002's plan of care was not updated to reflect the discontinued use of glasses and assistive devices, that the plan did not set out clear direction and that education was not given to all staff, the licensee failed to comply with the order.

Non-compliance has been previously identified under inspection 2015_331595_0006, including an order served May 20, 2015, to be complied by May 29, 2015. Ongoing non-compliance was identified during a follow up inspection, #2015_320612_0018, and an order was served on November 25, 2015 to be complied by December 30, 2015. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the staff and others who provided direct care to a resident were kept aware of the content of the resident's plan of care and had

convenient and immediate access to it.

Resident #002 was observed in the dining room with an adaptive device for meals. PSW #101 was observed feeding the resident in a specific way.

PSW #103 was observed serving dessert to resident #002. PSW #103 fed the resident in a specific way.

A review of the care plan indicated interventions related to assisting the resident with eating directed staff to assist the resident a specified way (which was not what the inspector had observed) and that the resident had a specified adaptive device (which was not what the inspector had observed the resident using) for their meals.

During an interview, PSW #102 and #103 stated to the Inspector that if they had questions regarding the care of a resident, they would ask the charge RN or RPN. They also stated that PSWs had not used the care plans. The care plans in the staff lounge were used by the RPN for the Resident Assessment Instrument (RAI) completion. They further stated that changes to a resident's plan of care were discussed during report at the beginning of the shift. PSW #102 and #103 were unsure where the interventions for the focus of eating were listed in the resident's plan of care when requested by the Inspector, and PSW #102 was unable to find the interventions for eating when provided with the resident's care plan. PSW #103 further stated they had never been directed to use the care plans during their orientation. PSW #102 and #103 indicated that the information from the care plan was not easily accessible to them.

During an interview, the Chief Nursing Officer confirmed to the Inspector that front line staff should have had more convenient and quick access to the resident's care plan. [s. 6. (8)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident had the following documented:
5) The person who applied the device and the time of the application.
6) All assessment, reassessment and monitoring, including the resident's response.
7) Every release of the device and all repositioning.
8) The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraint care.

Inspector #627 reviewed resident #002's care plan which indicated that the resident was at risk for falls and directed the staff to ensure that three specific restraints were in use as needed.

A review of the Restraint Administration Record for a period of time, for resident #002 revealed documentation for the use of two of the restraints. There was no documentation for the use of the third restraint.

A review of the Use of Restraint policy dated May, 2011, indicated that documentation for the use of a restraint must include who applied the restraints, the time of application, all assessments and reassessments, monitoring including patient's response and the removal of the restraint.

During an interview, PSW #001 stated two of the restraints were documented together instead of seperatly.

During an interview, the Chief Nursing Officer confirmed that all restraints used must be documented on the Restraint Administration Record and this documentation was not completed. [s. 110. (7)]

Issued on this 10th day of May, 2016

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE BYRNES (627)
Inspection No. / No de l'inspection :	2016_269627_0006
Log No. / Registre no:	033553-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Mar 31, 2016
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) (b)

Linked to Existing Order / Lien vers ordre existant: 2015_320612_0018, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance under s.6(1) of the Act. This plan is to include:

1. The development and implementation of a process to ensure that for resident #002 and all other residents, a thorough review is conducted of their plan of care.

2. That specifically for resident #002, their plan of care is reviewed to ensure the following:
- the plan care is revised to specifically reflect their needs related to vision;
- that it sets out clear direction to staff and others who provide direct care to the resident specific to the resident's assessed needs related to their feeding assistance.

3. The development and implementation of an auditing process that will identify when plans of care are not providing clear direction so that corrective actions can be taken.

4. That all staff who provide direct care to residents, are trained in the development, implementation and access of plans of care.

This plan shall be submitted in writing to Sylvie Byrnes, Long Term Care Homes Nursing Inspector, Long-Term Care Inspection Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at (705) 564-3133 or email sylvie.byrnes@ontario.ca. This Plan must be submitted by April 13, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to resident #002.

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

Resident #002 was observed in the dining room with an adaptive device for meals. PSW #101 was observed feeding the resident in a specific way. The resident was also observed not wearing glasses.

During another meal, resident #002 was observed in the dining room with an adaptive device. PSW #103 was observed feeding the resident in a specific way.

The resident was again observed not wearing glasses.

A review of the care plan indicated interventions related to assisting the resident with eating which directed the staff to assist the resident a specified way (which was not what the inspector had observed) and that the resident had a specified adaptive device (which was not what the inspector had observed) for their meals. According to the same care plan, interventions related to the resident's inability to focus on objects included: "Ensure eyeglasses are clean, appropriate and being worn by resident".

During an interview, the Speech Pathologist stated to the Inspector that they were not aware of any choking risks or interventions for preventing choking for resident #002.

During an interview, PSW #101 stated resident #002 no longer used adaptive tools for eating. They had trialed them and the resident did not like using them. They further stated that resident #002 had never worn glasses.

During an interview, PSW #103 stated that resident #002 had trialed adaptive tools but they were discontinued. As well, PSW #103 stated the resident didn't wear glasses. This was further confirmed by another PSW sitting at the next table.

During an interview, PSW #102 and #103 stated to the Inspector that if they had questions regarding the care of a resident, they would ask the charge RN or RPN. They further indicated that changes to a resident's plan of care were discussed during report at the beginning of the shift. PSW #102 and #103 were unsure where interventions for the focus of eating were listed in the resident's plan of care when requested by the Inspector, and PSW #102 was unable to find the interventions for eating when provided with the resident's care plan. PSW #103 further stated they had never been directed to use the care plans during their orientation.

During an interview, the Chief Nursing Officer confirmed to the Inspector that the plan of care did not set out clear directions to staff and others who provided direct care to the resident.

The licensee was previously ordered during inspection 2015_320612_0018 to complete a thorough review of resident #002's plan of care to ensure that the

planned care was reviewed and updated, set out clear direction to staff and others who provided direct care and that education was provided to all staff related to plan of care development and implementation. Given that resident #002's plan of care was not updated to reflect the discontinued use of glasses and assistive devices, that the plan did not set out clear direction and that education was not given to all staff, the licensee failed to comply with the order.

Non-compliance has been previously identified under inspection 2015_331595_0006, including an order served May 20, 2015, to be complied by May 29, 2015. Ongoing non-compliance was identified during a follow up inspection, #2015_320612_0018, and an order was served on November 25, 2015 to be complied by December 30, 2015. [s. 6. (1) (c)]

The decision to re-issue this compliance order was based on the fact that the licensee was previously ordered during inspection 2015_320612_0018 to complete a thorough review of resident #002's plan of care to ensure that the planned care was reviewed and updated, sets out clear direction to staff and others who provided direct care and that education was provided to all staff related to plan of care development and implementation. Given that resident #002's plan of care was not updated to reflect the discontinued use of glasses and assistive devices, that the plan did not set out clear direction and that education was not given to all staff, the licensee failed to comply with the order. (627)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 29, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 31st day of March, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Sylvie Byrnes

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