Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 11, 2016	2016_275536_0015	024553-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. PETER'S CARE CENTRES
125 Redfern Ave HAMILTON ON L9C 7W9

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

ST. PETER'S RESIDENCE AT CHEDOKE
125 Redfern Avenue HAMILTON ON L9C 7W9

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

CATHIE ROBITAILLE (536), LESLEY EDWARDS (506), LISA VINK (168), SAMANTHA DIPIERO (619), YULIYA FEDOTOVA (632)

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): August 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30, 31, September 1 and 2, 2016.

During the course of this Resident Quality Inspection (RQI) the following intakes were inspected concurrently:

Critical Incident System (CIS)

Log #008394-15 related to: prevention of abuse and neglect
Log #011536-15 related to: prevention of abuse and neglect
Log #021563-15 related to: prevention of falls
Log #026519-15 related to: prevention of abuse and neglect
Log #028950-15 related to: prevention of falls
Log #000866-16 related to: prevention of abuse and neglect
Log #005764-16 related to: lifts and transfers
Log #007435-16 related to: responsive behaviours, prevention of falls
Log #007642-16 related to: responsive behaviours
Log #014240-16 related to : prevention of abuse and neglect
Log #015097-16 related to : responsive behaviours
Log #020681-16 related to : responsive behaviours
Log #021584-16 related to : responsive behaviours
Log #019843-16 related to : prevention of falls
Log #025814-16 related to: responsive behaviours
Log #024591-16 related to: responsive behaviours
Log #026702-16 related to: lifts and transfers, prevention of abuse and neglect, skin and wound

Complaints

Log #000352-16 related to: prevention of abuse and neglect, responsive behaviours
Log #007519-16 related to: admission and discharge

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW's), registered staff, dietary staff, Food Service Supervisor, Resident Advisor-Social Worker, Coordinator of Volunteer Services, Community Care Access Centre (CCAC), Director of Quality and Clinical Practice, Resident Care Supervisors, Director of Resident Services, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured the home, observed meal and snack services, observed the provision of care and services provided on all home areas, interviewed staff, residents and families, and reviewed relevant documents including, health care records, investigation reports, training records, meeting minutes, menus and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **7 VPC(s)**
- **3 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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A) A review of the home's investigation notes for resident #024 identified that on a specified date in 2016, the resident had been placed on the toilet between the identified hours. At an identified time during the first safety check of the next shift, a Personal Support Worker (PSW) found resident #024 in the bathroom.

i) During interview with the staff who had worked on the specified date in 2016, staff #157 and #158 both stated that they had placed the resident on the toilet and had left the resident in the bathroom unattended to go and provide care to other residents. Both staff also identified that they were aware that the resident was only able to use the call bell intermittently. In turn, they both stated that they had forgotten to return to the resident. The care plan for resident #024 also identified that the resident was to be toileted at a specified time. Both staff stated during interview that the resident's care plan was not being followed. When staff #157 was interviewed and asked by the Inspector if resident #024 would have been offered a beverage and snack, staff #157 stated that resident #024 always refused nourishments so staff did not enter the residents room any longer to offer a beverage or snack. The care plan for resident #024 also stated they were at risk for falls. Interventions included but were not limited to: call bell within reach and check every hour to ensure safety. The two PSWs both stated that they were unaware that they were required to do hourly safety checks on all residents. The home's policy "Safety Check of Residents" policy number: 1-10, last revised: December 2013 stated: "At the beginning and end of every shift, the PSWs are to inform the registered staff person about the whereabouts of all residents on their assignments. Hourly checks will be done by PSW staff of all residents in their assignment. Hourly checks must be visual, no assumptions can be made regarding a residents whereabouts."

ii) Registered staff #153 who worked the specified date in 2016 when interviewed, confirmed that they had given resident #024's physician ordered treatment earlier than the physician's order required. Registered staff #153 also confirmed when interviewed that they had not completed any of the ordered treatments on that shift.

iii) During interview the Director of Care (DOC) confirmed that only new hires had received training in 2015 for safe lift and transfers and was unable to provide a date when all staff had last received training on safe lifts and transfers. (536)

B) On an specified date in 2015, resident #021 told staff #150 that they did not like staff #148 because they yelled at them. Staff #150 when interviewed stated they witnessed staff #148 say an identified comment to resident #021 and then staff #148 stuck their tongue out at resident #021. On the same day, staff #150 then confirmed with the

Inspector that they then heard staff #148 yelling at resident #023. Following the home's investigation, staff #148 was disciplined. (536)

C) On a specified date in 2016, resident #032, who was dependent on staff to assist with their activities of daily living, reported that PSW #126 verbally refused their request for assistance, argued with them and used profane language when speaking with them.

i)The resident confirmed that the assistance was provided following the verbal exchange, with the assistance of PSW #126 and PSW #127; however, the staff failed to provide them with a call bell when they were left unattended. Interview with the resident also confirmed that they did not like how the PSW spoke with them and that this was upsetting for them.

ii)Interview with PSW #126 confirmed that she initially refused the request of the resident and that they spoke to the resident inappropriately on the identified date, prior to the eventual provision of care.

iii)The internal investigative notes recorded by the staff at the home verified that during an interview with PSW #127 it was confirmed that they failed to provide the resident with a call bell as required. The resident was not protected from abuse. (168) [s. 19. (1)]

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were transferred using safe transferring and positioning techniques.

A) A review of the home's investigation notes for resident #024 identified that on an specified date in 2016 they had placed the resident on the toilet unattended. At an identified time during the first safety check of the next shift, a PSW found resident #024 in the bathroom. During interview with the staff who had worked on the specified date in 2016, staff #157 and #158 both stated that they had left the resident in the bathroom unattended to go and provide care to other residents and forgot to return to resident #024. Both staff also identified that they were aware that the resident was only able to use the call bell intermittently. Both staff #157 and #158 identified during interview that there were unaware that they were required to do hourly safety checks on all residents. The home's policy "Safety Check of Residents" policy number: 1-10, last revised: December 2013 stated: "At the beginning and end of every shift, the PSW's are to inform the registered staff person about the whereabouts of all residents on their assignments. Hourly checks will be done by PSW staff of all residents in their assignment. Hourly checks must be visual, no assumptions can be made regarding a residents whereabouts." During interviews the DOC, staff #157 and staff #158 confirmed to the Inspector that safe techniques were not used for resident #024. (536)

B) A review of the home's investigation notes for resident #021 identified that on a specified date in 2015, the resident was complaining of pinching and pain when they were being transferred in a sling from the shower chair to the bed. During interview staff #145 confirmed the wrong size of sling had been used on resident #021. The licensee failed to ensure that the proper sling was used on resident #021. (536)

C) On a specified date in 2015, resident #044 was receiving care by one personal support worker (PSW) while in bed. The PSW turned away and the resident fell sustaining an injury. The PSW proceeded to manually lift the resident by themselves from the floor back to their bed, before reporting the incident to their supervisor and before the resident was assessed for any further injuries. Resident #044's plan of care confirmed that the resident was to have care provided by two people and that they were a mechanical lift for all transfers. The home's policy for Lifting and Transfers directs staff members if a resident is on the floor all lifting must be performed mechanically and the registered staff will complete assessment for possible injury. Staff #130 confirmed that the PSW did not follow safe transferring techniques and the resident was not transferred using safe transferring and positioning techniques. (506) [s. 36.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. A) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention.

1)Regulation 221(2) 1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all areas required under subsection 76(7) of the Act.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all staff had been retrained on zero tolerance of abuse and neglect of residents. There were only an identified percentage of the home's staff retrained in 2015. The home's training records, Administrator and staff #143 confirmed

that not all staff had received annual retraining in the prevention of abuse and neglect. (536)

B) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 3. Behaviour Management.

Regulation 221 (3), requires training for all staff who provide direct care to residents related to responsive behaviours.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all direct care staff had been retrained on responsive behaviours. Training records for 2015, identified that there were only an identified number of direct care staff attended training on behaviour management. The Administrator and staff #143 confirmed that that not all direct care staff received the required training. (506)

C) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1) Regulation 221(1)1, requires training for all staff who provide direct care to residents related to falls prevention and management.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all direct care staff had been retrained on falls prevention and management. Training records for 2015, identified that there were only an identified number of direct care staff attended training on fall prevention. The Administrator and staff #143 confirmed that not all direct care staff received the required training. (506)

D) The licensee has failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1)Regulation 221 (1) 2, requires training for all staff who provide direct care to residents

related to skin and wound care.

A review of the 2015 skin and wound care training records specified that there was only an identified number of direct care staff trained on skin and wound care.

An interview with the Director of Care (DOC) confirmed that only direct care staff, including Registered Nurses and Registered Practical Nurses complete skin and wound assessments and interventions including ongoing treatments and referrals. The DOC confirmed that not all direct care staff received the required training. (619)

E) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1)Regulation 221(2) 1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all areas required under subsection 76(7) of the Act.

During interview the Director of Care was unable to identify the last time that safe lifts and transfers training was completed for anyone other than new hires. In 2016 they have started to do training with performance appraisals and an identified percentage of personal support workers (PSW's) have been trained to date. (536)

F) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1)Regulation 221(2) 1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:1. Subject to paragraph 2, the staff must receive annual training in all areas required under subsection 76(7) of the Act.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all staff had been retrained on the residents' bill of rights; the duty to make mandatory reports under section 24; and the whistle-blowing

protections. There were only an identified percent of the home's staff retrained in 2015. The home's training records, Administrator and staff #143 confirmed that not all staff had received annual retraining in the prevention of abuse and neglect. (536) [s. 76. (7)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

A) The home's "Non-Abuse of Resident" policy number 2-60, last revised: April 2016, indicated that: The resident's Substitute Decision Maker (SDM) will be made aware immediately of any alleged, suspected or witnessed incident of abuse and the home will record the date, time, the alleged, suspected or witnessed incident of abuse took place and that family notification has occurred and is documented in the residents confidential progress record.

i) Resident #041 was involved in an identified interaction with co-resident #040 on specified dates in 2016. A review of resident #041's clinical record did not include the required documentation such as the date and time the SDM was notified regarding the alleged abuse. Staff #129 confirmed that the home's abuse policy was not complied with.

ii) Resident #045 was involved in an alleged incident of abuse with a staff member on a specified date in 2015. A review of resident 045's clinical record did not include the alleged incident in the resident's clinical record. Staff #131 confirmed that the home's abuse policy was not complied with. (506)

B) The home's "Non-Abuse of Resident" policy number 2-60, last revised: December 2014, indicated that: Every staff member in all disciplines and at all levels have an obligation and a duty to immediately report any act of resident abuse such as physical abuse, emotional abuse, financial abuse, neglect, sexual abuse or verbal abuse.

i)Resident #021 and #023 were witnessed to have been allegedly verbally abused by staff #148 in May 2015. Staff #150 who was working that day reported it to staff #101 that same day. However, it was not reported to the management of the home's attention until four days later. This was confirmed by staff #101. (536) [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

A) Resident #051 was involved in a altercation with a co-resident on a specified date in 2016. Resident #051 received a head to toe assessment by registered staff and was noted to have bleeding, and identified injury. A review of the resident's clinical record did not indicate that a skin and wound assessment was completed. (619)

B) Resident #052 was involved in a altercation with a co-resident on a specified date in 2016. The resident was noted to have identified injuries with minor bleeding. A review of the resident's clinical record did not indicate that a skin and wound assessment was completed. (619)

C) Resident #053 was involved in a altercation with a co-resident on a specified date in 2016, and was noted to have an injury. A review of the resident's health record did not indicate that a skin and wound assessment was completed. (619)

A review of the home's policy "Skin and Wound – Skin and Wound Management", policy number: #10-1, last revised: April 2016, stated that resident's with altered skin integrity will have their wound/rash assessed weekly, and that registered staff will use a clinically appropriate assessment instrument that is specifically designed for skin and wound care. Interview with staff #153 indicated that when a resident has had a change in the condition of their skin that a formalized skin and wound assessment is completed so that staff can monitor changes in the resident's skin and help to promote healing. An interview with the Director of Care (DOC) confirmed that the skin and wound assessments for resident's #051, #052, and #053 were not completed. [s. 50. (2) (b) (i)]

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 and ensuring that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds, receives a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment specifically designed for skin and wound assessments, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy and procedure for falls prevention and post fall management program was complied with.

A)Resident #053 was involved in an altercation on an identified date in 2016, with a co-resident and had a noted injury. An interview with registered staff #153 indicated that when a resident has an unwitnessed fall, the Head Injury Routine(HIR) is to be initiated by the registered staff to monitor the resident's neurological vital signs to assess for injuries post fall. A review of the resident's clinical record indicated that the resident's neurological vital signs were not monitored after the unwitnessed fall. The home's policy "Falls Management and Post Falls Management Program", policy number: #9-1, last revised: January 2015, stated: if the fall was unwitnessed, or a resident has hit their head, a Head Injury Routine/Neuro Vitals Assessment will be initiated. An interview with the DOC confirmed that the registered staff failed to comply with the home's Head Injury Routine policy. (619)

B)The home's policy "Falls Prevention and Post Fall Management Program, Resident Care Manual" policy number: 9-1, last revised: January 20, 2014 stated: that when a resident has fallen the resident will have a fall risk assessment completed within 24 hours of the fall and if the fall was unwitnessed, or a resident has hit their head, a Head injury routine/ Neuro-vital assessment will be initiated.

i. Resident #047 sustained a fall on a specified date in 2016 and time and sustained an injury. A review of the clinical record confirmed that a post fall assessment had not been completed until an identified date. Staff #129 confirmed that the home's policy for fall prevention was not complied with.

ii. Resident #046 sustained a near miss fall, it was witnessed that the resident had bumped their head. Record review and staff #118 confirmed that head injury routine / neuro-vital assessment was not completed and confirmed that the home's fall prevention policy was not complied with. (506) [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that policy and procedures for falls prevention and post-falls management are complied with, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions.

i. On an identified date in 2016, resident #040 was seated next to co-resident #041 and resident #040 was exhibiting responsive behaviours towards resident #041. The residents were redirected away from each other; however, when staff returned from break the residents were seated next to each other and resident #040 was once again displaying responsive behaviour towards resident #041.

ii. On an identified date in 2016, resident #040 was seated in an identified area. Resident #041 was standing next to the resident #040 and was displaying responsive behaviours. It was identified in the resident #040's plan of care that the resident should not be seated by these residents, or left alone with these residents as the resident has a history of inappropriate behaviours towards them. Interview with staff #129 confirmed that the home did not take steps to minimize the risk of potentially harmful interactions by implementing the interventions that were identified as a trigger for resident #040. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the medication cart was secured and locked.

On August 25, 2016, the medication cart was noted to be unlocked and unattended in the hallway on a specified date and time in an identified home area. The Inspector heard staff #137 conversing with a resident in a room. The inspector was able to open and close the medication drawer including the narcotic drawer without staff #137 being aware. At that time, there were residents wandering in the hallway. The staff member returned to the cart approximately three to five minutes later and confirmed that the medication cart should have been locked. [s. 129. (1) (a)]

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 and ensuring that the medication care is secured and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents demonstrating responsive behaviors the behavioral triggers are identified and strategies are developed and implemented to respond to these behaviors as evidenced by:

A review of resident #041's clinical record identified that the resident had several incidents of responsive behaviors with co-residents. The home had a focus statement regarding the responsive behaviours; however, did not identify specific strategies or implement interventions to prevent these responsive behaviours from occurring. Staff #128 confirmed that strategies were not identified and documented to direct staff how to respond to these responsive behaviours. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that residents demonstrating responsive behaviours the behavioural triggers are identified and strategies developed and implemented to respond to these behaviours, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

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

Resident #050 had a history of responsive behaviours. The resident was assessed by the Behavioural Support Ontario (BSO), and the resident's written plan of care was updated to include strategies and interventions to reduce the instances of responsive behaviours. The written plan of care last updated on a specified date in 2016, stated that resident #050 was to be kept separate from identified co-residents that triggered resident #050's behaviours, but did not identify in the resident's clinical records who those two co-residents were. During interview, staff #161 was unable to identify the resident's that were to be kept away from resident #050. Staff #160 confirmed that the names of the two residents were not identified in resident #050's plan of care, and that staff were expected

to verbally relay who the identified co-residents were. The Director of Care (DOC) when interviewed confirmed, that the written plan of care did not set out clear directions to staff who provide direct care to resident #050. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident's substitute decision maker was given the opportunity to participate fully in the implementation of the residents' plan of care.

A review of resident #020's clinical record identified that on an identified date in 2015 there had been Multi-disciplinary Care Conference (MDCC) for the resident. The resident's substitute decision maker (SDM) reluctantly agreed for the resident to be referred for an identified assessment and intervention to be in place. On an identified date in 2015 resident #020 became aggressive towards the staff. It was not until the resident was being transferred to the hospital which was a specified number of hours after the aggression towards the staff, that the SDM of resident #020 was notified about the resident's responsive behaviour towards staff. This was confirmed by the Director of Care. [s. 6. (5)]

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

A) The plan of care for resident #024 stated the resident was to be toileted at identified times and as needed. As well, the plan of care stated that the resident was at high risk for falls and was to be checked every hour to ensure safety. A review of the home's investigation notes for resident #024 identified that on an identified date in 2016, the resident had been placed on the toilet and left unattended. At an identified time during the first safety check of the next shift a personal support worker (PSW) found resident #024 in the bathroom. During interview with the staff who had worked the identified date in 2016, staff #157 and #158 both stated that they had left the resident in the bathroom unattended to go and provide care to other residents. Both staff also identified that they were aware that the resident was only able to use the call bell intermittently. In turn they both forgot to return to the resident, and completed their shifts and left the building. Both staff also confirmed during interview that the resident was not being toileted at an identified time as per the residents plan of care. (536)

B) Resident #021's plan of care in place on a specified date in 2015, stated that the resident required the use of a specified sling for transfers. A review of the home's investigation notes for resident #021 identified that on an identified date in 2015, the

resident was complaining of pinching and pain when they were being transferred in a sling from the shower chair to the bed. During interview staff #145 confirmed the wrong size of sling had been used on resident #021. (536)

C) Resident #044's plan of care directed staff that the resident was to have two staff for care. On a specified date in 2015, the resident was receiving care by only one staff. When the staff member turned their back to the resident the resident fell. Staff #130 confirmed at the time of the fall the staff member was not following the resident's plan of care which required two staff present for morning care. (506) [s. 6. (7)]

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

A) Resident #040 was recently admitted to the home and was experiencing specified responsive behaviours and required an identified intervention between identified hours. During an observation of the resident on an identified date in 2016, the resident had an intervention in place with a female staff. The plan of care directed that the resident was only to have male staff providing this intervention, and that the staff would be at the home between identified hours. An interview with staff #129 revealed that the resident receives this intervention between identified hours and the staff will be male if available. Staff #129 confirmed that the care plan was not reviewed and revised to include the resident's current interventions. (506)

B) On an specified date in 2016, resident #041 was observed in the hallway on their own. A review of the resident's care plan indicated that the resident was to have an identified intervention. An interview with staff #129 confirmed that the resident has not had this intervention since an identified date in 2016. Staff #129 confirmed that the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the written plan of care for the resident provides clear direction for staff and others who provide direct care to residents; substitute decision makers are given and opportunity to participate full in the implementation of the residents plan of care; care set out in the plan of care is provided as specified in the plan and that residents was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that the food production system at minimum provided communication to residents and staff of any menu substitutions.

On August 16, 2016, during lunch observation, coleslaw salad was served to the residents, which was not included in the posted week 1 Spring/Summer 2016 Menu. An interview with staff #120 identified that the carrot raisin salad posted on the menu was substituted for coleslaw salad for lunch. This was confirmed by Food Service Supervisor. The posted Spring/Summer 2016 menu did not provided communication to residents and staff of some lunch menu substitutions. [s. 72. (2) (f)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that all staff participated in the implementation of the infection prevention and control program.

i. On August 16, 2016, during the initial tour of the home, in the bathing suite on a specified home area, an unlabeled, used hair comb, was observed, as well as an unlabelled electrical razor. Staff #103 confirmed that these items were to be labelled to ensure they were used only on one resident.

ii. On August 16, 2016, during the initial tour of the home, in the bathing suite on a specified home area, an unlabeled, used hair comb, was observed. Staff #102 confirmed that these items were to be labelled to ensure they were used only on one resident.

The Director of Care also confirmed that all items for personal care are to be labelled to ensure they are used by only one resident. [s. 229. (4)]

Issued on this 20th day of October, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHIE ROBITAILLE (536), LESLEY EDWARDS (506), LISA VINK (168), SAMANTHA DIPIERO (619), YULIYA FEDOTOVA (632)
Inspection No. / No de l'inspection :	2016_275536_0015
Log No. / Registre no:	024553-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 11, 2016
Licensee / Titulaire de permis :	ST. PETER'S CARE CENTRES 125 Redfern Ave, HAMILTON, ON, L9C-7W9
LTC Home / Foyer de SLD :	ST. PETER'S RESIDENCE AT CHEDOKE 125 Redfern Avenue, HAMILTON, ON, L9C-7W9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Renee Guder

To ST. PETER'S CARE CENTRES, 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)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home protects residents from abuse and neglect by staff. The plan is to include but is not limited to:

- Implementation of the home's abuse policy and procedures to mitigate the risk to residents so they are not exposed to possible or potential abuse and neglect.
-Training of all staff annually on prevention of abuse and neglect
-Training of all staff on hourly safety checks
-Training of registered staff on following physician prescribed ordered times for medications and treatments

The plan is to be submitted on or before December 12, 2016 by email at Cathie. Robitaille@ontario.ca.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (3), scope (2), and compliance history (4), in keeping with s. 19(1) of the Act, in respect to severity of actual harm/risk for resident #024, #021,#023 and #032, the scope of this being a pattern, and the licensee history of non-compliance with a (VPC) April 2015, during the Resident Quality Inspection for s. 19 (1).

The licensee has failed to ensure that residents are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

A) A review of the home's investigation notes for resident #024 identified that on a specified date in 2016, the resident had been placed on the toilet between the

identified hours. At an identified time during the first safety check of the next shift, a Personal Support Worker (PSW) found resident #024 in the bathroom.

i) During interview with the staff who had worked on the specified date in 2016, staff #157 and #158 both stated that they had placed the resident on the toilet and had left the resident in the bathroom unattended to go and provide care to other residents. Both staff also identified that they were aware that the resident was only able to use the call bell intermittently. In turn, they both stated that they had forgotten to return to the resident. The care plan for resident #024 also identified that the resident was to be toileted at a specified time. Both staff stated during interview that the resident's care plan was not being followed. When staff #157 was interviewed and asked by the Inspector if resident #024 would have been offered a beverage and snack, staff #157 stated that resident #024 always refused nourishments so staff did not enter the residents room any longer to offer a beverage or snack. The care plan for resident #024 also stated they were at risk for falls. Interventions included but were not limited to: call bell within reach and check every hour to ensure safety. The two PSWs both stated that they were unaware that they were required to do hourly safety checks on all residents. The home's policy "Safety Check of Residents" policy number: 1-10, last revised: December 2013 stated: "At the beginning and end of every shift, the PSWs are to inform the registered staff person about the whereabouts of all residents on their assignments. Hourly checks will be done by PSW staff of all residents in their assignment. Hourly checks must be visual, no assumptions can be made regarding a residents whereabouts."

ii) Registered staff #153 who worked the specified date in 2016 when interviewed, confirmed that they had given resident #024's physician ordered treatment earlier than the physician's order required. Registered staff #153 also confirmed when interviewed that they had not completed any of the ordered treatments on that shift.

iii) During interview the Director of care (DOC) confirmed that only new hires had received training in 2015 for safe lift and transfers and was unable to provide a date when all staff had last received training on safe lifts and transfers. (536)

B) On an specified date in 2015, resident #021 told staff #150 that they did not like staff #148 because they yelled at them. Staff #150 when interviewed stated they witnessed staff #148 say an identified comment to resident #021 and then staff #148 stuck their tongue out at resident #021. On the same day, staff #150

then confirmed with the Inspector that they then heard staff #148 yelling at resident #023. Following the home's investigation, staff #148 was disciplined. (536)

C) On a specified date in 2016, resident #032, who was dependent on staff to assist with their activities of daily living, reported that PSW #126 verbally refused their request for assistance, argued with them and used profane language when speaking with them.

i)The resident confirmed that the assistance was provided following the verbal exchange, with the assistance of PSW #126 and PSW #127; however, the staff failed to provide them with a call bell when they were left unattended. Interview with the resident also confirmed that they did not like how the PSW spoke with them and that this was upsetting for them.

ii)Interview with PSW #126 confirmed that she initially refused the request of the resident and that they spoke to the resident inappropriately on the identified date, prior to the eventual provision of care.

iii)The internal investigative notes recorded by the staff at the home verified that during an interview with PSW #127 it was confirmed that they failed to provide the resident with a call bell as required. The resident was not protected from abuse. (168)
(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the home protects residents from abuse and neglect by staff. The plan is to include but is not limited to:

- Implementation of the home's abuse policy and procedures to mitigate the risk to residents so they are not exposed to possible or potential abuse and neglect.
-Training of all staff annually on prevention of abuse and neglect
-Training of all staff on hourly safety checks
-Training of registered staff on following physician prescribed ordered times for medications and treatments

The plan is to be submitted on or before December 12, 2016 by email at Cathie. Robitaille@ontario.ca.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (3), scope (3), and compliance history (2), in keeping with r. 36 of the Regulations, in respect to severity of actual harm/risk for resident #024, #021 and #044, the scope of this being widespread, and the licensee compliance history of no non-compliance for r. 36.

The licensee has failed to ensure that residents were transferred using safe transferring and positioning techniques.

A) A review of the home's investigation notes for resident #024 identified that on an specified date in 2016 they had placed the resident on the toilet unattended. At an identified time during the first safety check of the next shift, a PSW found

resident #024 in the bathroom. During interview with the staff who had worked on the specified date in 2016, staff #157 and #158 both stated that they had left the resident in the bathroom unattended to go and provide care to other residents and forgot to return to resident #024. Both staff also identified that they were aware that the resident was only able to use the call bell intermittently. Both staff #157 and #158 identified during interview that there were unaware that they were required to do hourly safety checks on all residents. The home's policy "Safety Check of Residents" policy number: 1-10, last revised: December 2013 stated: "At the beginning and end of every shift, the PSW's are to inform the registered staff person about the whereabouts of all residents on their assignments. Hourly checks will be done by PSW staff of all residents in their assignment. Hourly checks must be visual, no assumptions can be made regarding a residents whereabouts." During interviews the DOC, staff #157 and staff #158 confirmed to the Inspector that safe techniques were not used for resident #024. (536)

B) A review of the home's investigation notes for resident #021 identified that on a specified date in 2015, the resident was complaining of pinching and pain when they were being transferred in a sling from the shower chair to the bed. During interview staff #145 confirmed the wrong size of sling had been used on resident #021. The licensee failed to ensure that the proper sling was used on resident #021. (536)

C) On a specified date in 2015, resident #044 was receiving care by one personal support worker (PSW) while in bed. The PSW turned away and the resident fell to the floor sustaining an injury. The PSW proceeded to manually lift the resident by themselves from the floor back to their bed, before reporting the incident to their supervisor and before the resident was assessed for any further injuries. Resident #044's plan of care confirmed that the resident was to have care provided by two people and that they were a mechanical lift for all transfers. The home's policy for Lifting and Transfers directs staff members if a resident is on the floor all lifting must be performed mechanically and the registered staff will complete assessment for possible injury. Staff #130 confirmed that the PSW did not follow safe transferring techniques and the resident was not transferred using safe transferring and positioning techniques. (506)
(536)

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 : Dec 30, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all staff receive annual training. The plan is to include but is not limited to:

- All direct care staff trained on abuse recognition and prevention
-All direct care staff trained on safe use of lifts and transfers
-All direct care staff trained on skin and wound care
-All direct care staff trained on behaviour management
-All direct care staff trained on falls prevention and management

The plan is to be submitted on or before December 12, 2016 by email to Cathie Robitaille at Cathie. Robitaille@ontario.ca.

Grounds / Motifs :

1. This order is made up on the application of the factors of severity (2), scope (3), and compliance history (3), in keeping with s. 76 (1), 76 (2) 10, 76 (4), 76 (7) 3, and 76 (7) 6 of the Act, in respect to severity of Minimal Harm/Risk or Potential for Actual Harm/Risk, the scope of this being widespread, and the licensee history of non-compliance for training in the Regulations section 221.

A) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention.

1)Regulation 221(2) 1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all areas required under subsection 76(7) of the Act.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all staff had been retrained on zero tolerance of abuse and neglect of residents. There were only an identified percentage of the home's staff retrained in 2015. The home's training records, Administrator and staff #143 confirmed that not all staff had received annual retraining in the prevention of abuse and neglect. (536)

B) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 3. Behaviour Management.

Regulation 221 (3), requires training for all staff who provide direct care to residents related to responsive behaviours.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all direct care staff had been retrained on responsive behaviours. Training records for 2015, identified that there were only an identified number of direct care staff attended training on behaviour management. The Administrator and staff #143 confirmed that that not all direct care staff received the required training. (506)

C) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1) Regulation 221(1)1, requires training for all staff who provide direct care to residents related to falls prevention and management.

The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all direct care staff had been retrained on falls prevention and management. Training records for 2015, identified that there were only an identified number of direct care staff attended training on fall prevention. The Administrator and staff #143 confirmed that not all direct care staff received the required training. (506)

D) The licensee has failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1)Regulation 221 (1) 2, requires training for all staff who provide direct care to residents related to skin and wound care.

A review of the 2015 skin and wound care training records specified that there was only an identified number of direct care staff trained on skin and wound care.

An interview with the Director of Care (DOC) confirmed that only direct care staff, including Registered Nurses and Registered Practical Nurses complete skin and wound assessments and interventions including ongoing treatments and referrals. The DOC confirmed that not all direct care staff received the required training. (619)

E) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1)Regulation 221(2) 1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all areas required under subsection 76(7) of the Act.

During interview the Director of Care was unable to identify the last time that safe lifts and transfers training was completed for anyone other than new hires.

In 2016 they have started to do training with performance appraisals and an identified percentage of personal support workers (PSW's) have been trained to date. (536)

F) The licensee failed to ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 6. Any other areas provided for in the regulations.

1)Regulation 221(2) 1, requires that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:1. Subject to paragraph 2, the staff must receive annual training in all areas required under subsection 76(7) of the Act.
The Administrator and staff #143 were interviewed and were not able to provide documentation to reflect that all staff had been retrained on the residents' bill of rights; the duty to make mandatory reports under section 24; and the whistle-blowing protections. There were only an identified percent of the home's staff retrained in 2015. The home's training records, Administrator and staff #143 confirmed that not all staff had received annual retraining in the prevention of abuse and neglect. (536) [s. 76. (7)]

(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 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 soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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 soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
TORONTO, 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 11th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathie Robitaille

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