Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 07, 2017;	2017_668543_0004 (A1)	003891-17	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension to compliance due date requested and approved for CO #001 and #002.

Issued on this 7 day of November 2017 (A1)

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

Original report signed by the inspector.

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): July 4-7, 10-14 and 17, 2017

The following intakes were completed during this Resident Quality Inspection:

One Follow up intake from Inspection report #2017_615638_0003, related to s. 15 (1) of the Ontario Regulation (O. Reg.) 79/10, specific to training related to bed rail assessments, the use of the bed rail system and risks associated with bed rail use,

Three Critical Incident (CI) reports that were submitted to the Director related to falls.

Three CI reports that were submitted to the Director, related to abuse.

Three CI reports that were submitted to the Director related to Responsive Behaviours.

Throughout the inspection, the inspectors directly observed the delivery of care

and services to residents in all home areas, directly observed various meal services, reviewed resident health care records, reviewed staffing patterns and reviewed various home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Service Manager, Environmental Service Assistant, Registered Dietitian (RD), Food Service Assistant, Housekeeping staff, residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Dignity, Choice and Privacy

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

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

7 WN(s)
4 VPC(s)
3 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
O.Reg 79/10 s. 15. (1)	CO #001	2017_615638_0003	543

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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A Critical Incident (CI) report was submitted to the Director in February 2016. According to the CI report, resident #014 was found lying on the floor and unable to tell staff what had happened. The resident was complaining of pain and had an injury. The CI report also identified that the resident had a history of falling. The resident was sent to the hospital for assessment and returned to the home palliative. Resident #014 passed away.

Inspector #543 reviewed the home's policy titled "Falls Prevention and Management Program" with a revision date of May 4, 2017. This policy indicated that registered staff would initiate an inter-professional team review if a resident had two or more falls in 72 hours, or three or more falls in three months.

Inspector #543 reviewed resident #014's health care record and identified that this resident had fallen on specific dates in January and February 2017, having had three or more falls in less then three months. The Inspector was unable to identify that any Inter-professional Team Review/Team Conference was held to address this resident's falls.

Inspector #543 interviewed RN #118 regarding the Inter-professional Team Reviews/Team Conferences that were to be held post falls for residents. The RN verified that the policy "Falls Prevention and Management Program", which outlined the frequency of falls a resident had that would initiate an Inter-professional Team Review/Team Conference was accurate. The RN and the Inspector went through resident #014's health care record (care plan, progress notes and assessments) together, which indicated that no Inter-professional Team Reviews/Team Conferences were held for this resident for the falls that occurred on specific dates in January and February 2017.

On July 14, 2017, Inspector #543 interviewed the DOC, regarding the Inter-professional Team Reviews/Team Conferences that were to be held post falls for residents. The Inspector indicated that they had read in the home's Falls policy that it was required that those reviews were to be held if a resident fell two times (or more) in a 72 hour period or three times (or more) in a 3 month period. The DOC verified that was accurate and should happen for each resident who had numerous falls. The Inspector shared with the DOC that for resident #014 there

were none of the reviews completed for this resident for the falls that occurred on specific dates in January and February 2017. The DOC verified that no Inter-professional Team Reviews/Team Conferences were completed. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

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

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

WN #2: 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 plan of care set out clear directions to staff and others who provided direct care to the resident.

On July 05, 2017, during a family interview with Inspector #627, resident #008's substitute decision maker (SDM) voiced concerns regarding the care provided to the resident. They stated that they often would visit, and the resident would be without their dentures. They further stated that they had arrived on this day at 1000 hours and that the resident did not have their dentures in.

On July 10, 2017, at 0943 hours, Inspector #627 observed the resident sitting in

their room and did not have their dentures inserted.

Inspector #627 reviewed resident #008's care plan in effect at the time of the inspection which indicated specific interventions related to the focus of hygiene and grooming, specific to their denture care needs. The focus of eating and nutritional needs also identified specific interventions, specific to their denture care needs which were different from the hygiene and grooming denture focus.

On July 10, 2017, during an interview with the Inspector, PSW #104 stated that resident #008 had not required their dentures for breakfast.

On July 11, 2017, at 1000 hours, PSW #107 stated that resident #008 needed their dentures during meal time.

On July 12, 2017, during an interview with Inspector #627, RN #118 verified that there were conflicting interventions in the care plan with regards to resident #008's hygiene and grooming needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

The Long-Term Care Health Act, 2007, defines substitute decision maker as a person who is authorized under the Health Care Consent Act, 1996, or the Substitute Decision Act, 1992, to give or refuse consent or make a decision, on behalf of another person.

During a family interview with Inspector #627, resident #008’s family member, who was also the SDM for resident #008 stated that they remained upset over an incident that had occurred in December 2015. The family member informed the Inspector that resident #008 had been assessed by a Dietitian and a Speech Language Pathologist (SLP) as requiring a specific diet. The SDM stated that they understood the need for this; however, they knew resident #008 liked certain snacks that were not included in their their ordered diet and would provide the resident with these snacks. The SDM indicated that this was one of the only pleasures the resident experienced. They were aware of the risk and felt that the benefit outweighed the risks as this was providing the resident with something that they enjoyed. The SDM stated that in December 2015, a PSW had reported to the ADOC that they had given the resident a snack. The ADOC had approached them

in the resident's room and asked if they had been giving the resident a snack and had been told that the resident was only to have the diet specifically ordered for the resident. The SDM responded to the ADOC that they felt the resident enjoyed the treats and they would continue to provide them. At 1700 hours that day, the Administrator asked resident #008's SDM to meet with them in their office; whereby they informed the SDM that if they "continued to defy their authority, they would issue a no trespassing order and they would no longer be allowed on the property". The SDM felt the home had not respected them as the SDM. They adhered to the home's orders, to ensure they would continue to be allowed to visit the resident.

Inspector #627 reviewed resident #008's health care record, and noted a document which identified the complainant as the resident's SDM.

Inspector #627 interviewed PSW #103 who stated that when a family member fed a resident a food that was not the prescribed texture for the resident, they educated the family on the prescribed texture and the risks of providing the resident with any other textures other than the one specifically ordered for the resident. The PSW stated that they told resident #008's family that it was for the resident's safety and reported to the RPN, when family provided food textures other the one specifically ordered for the resident. The PSW stated they were unsure why the SDM's decision was not respected as resident #018 was often given food by their family which was not the prescribed texture; family and the SDM had been educated and if they chose to provide food that was not the prescribed texture, this was their choice.

Inspector #627 interviewed RPN #102 who stated that when a family member brought food for a resident which was not the prescribed texture, the RPN provided education to the family of the risks. Once the education had been completed, the family's wishes were respected if the resident was able to make their own decisions. It was different when the SDM made the decision for the resident, as this jeopardized the resident's safety. The RPN stated that resident #008 was to be provided only foods that were of a specific texture.

Inspector #627 interviewed the Dietitian who stated that when a resident, who was capable of making their own decisions, refused to follow the prescribed textured diet, education would be provided about the risks. If the resident continued to refuse the textured diet, they were provided with their food choice and it was documented that the resident had refused to follow the home's recommended food

texture. The Dietitian stated that in October 2015, resident #008 was assessed as requiring a specific diet. The SDM had continued to provide foods that were not of the recommended texture. They stated that the staff recorded at every meal that the SDM provided to the resident, a food or meal that was not the prescribed texture, that the resident coughed and took much longer to eat. They further stated that in December 2015, the ADOC and the Administrator had informed the SDM that if they continued to give the resident treats, they would issue a no trespass order and prevent the SDM from entering the home. The Dietitian stated that at one time, to respect the SDM and the resident's rights, they had allowed the resident to have treats; however, this was no longer permitted.

Inspector #627 interviewed the ADOC who stated that resident #008 was prescribed a specific diet by the Dietitian, the SLP and the Physician. The ADOC stated that if a resident who was capable of making their own decisions refused the prescribed diet, teaching would be done about the risks, information would be provided, and if they continued to refuse the prescribed textured diet, they were provided with the choice of texture. The Dietitian would remain involved and the family would also be involved. When a resident was no longer capable of making their own decision, and the SDM had not followed the recommended textured diet, they were provided with education "on the spot", and told that the prescribed diet texture had to be adhered to. The ADOC stated that the SDM could not go above medical orders. If they persisted in giving the resident treats that were not of the specific texture, they would be issued a no trespass order and would prevent the SDM from entering the home. They further stated that although the SDM could refuse a certain type of medication for a resident, that food choices were different and the home had documentation to support this.

Inspector #627 interviewed the Administrator who stated that in 2015, a PSW and Food Service Aid (FSA) had brought forth concerns that the family had requested a regular diet for the resident. They also reported that, the SDM continued to give the resident treats after having being spoken to by the ADOC, and the DOC about the risks. There were many occurrences and the Administrator said, "I had to speak to the SDM myself". "I told the SDM that they could not dictate over the Dietitian, the SLP and the Physician. If the SDM continued to provide food that was not of the prescribed texture, they would be issued a no trespass order and would prevent the SDM from entering the home". The decision was based on the role of the SDM and the resident was unable to make their own decisions. The Administrator stated they took a stand that the SDM could not go against the orders, particularly that they were doing it on the home's premises, that was the issue; the SDM could feed

the resident what they wanted when they were not in the home. When Inspector #627 asked how the resident's rights, and the SDM's wish to provide the resident with treats was respected, the Administrator stated that "the SDM could bring any type of food if they did not like the taste; however, it had to be in the prescribed texture". [s. 6. (5)]

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

During a family interview with Inspector #627, resident #008's SDM stated that they had concerns regarding the resident not being provided with specific care. Also, the SDM stated that the resident was often put to bed too early, although their care plan identified that the resident preferred going to bed later. The SDM stated that they had been told by the staff that the resident had to be in bed prior to them having their supper break, which was before the resident's preferred bed time, if they wanted assistance from a co-worker.

On July 06, 2017, at 1345 hours, Inspector #627 observed resident #008 in bed. The resident had dried food on their chin and in the corners of their mouth.

On July 10, 2017, at 1000 hours, Inspector #627 observed resident #008 in their room. The resident was not wearing their top denture. A dry electric toothbrush was observed on the resident's night table.

On July 10, 2017, at 1830 hours, Inspector #627 observed the resident in bed prior to their preferred bed time.

On July 11, 2017, at 0910 hours, the resident was observed in the dining room.The resident was not wearing their glasses.

The Inspector reviewed resident #008's care plan in effect at the time of the inspection and noted specific interventions related to specific care and ADLs, which were not consistent with what was observed.

On July 10, 2017, at 1000 hours, during an interview with Inspector #627, PSW #104 stated that the resident had received morning care, however, they had not had their dentures put in, nor had they received mouth care. The PSW stated that they were short staffed, and had not had the time to complete mouth care.

On July 10, 2017, at 1840 hours, during an interview with Inspector #627, PSW #110 stated that the resident had been put to bed between 1815 hours and 1825 hours. They stated that the resident had required assistance with specific ADLs and was then transferred to bed. They further stated that typically, when a resident was transferred to bed after supper, staff did not get them up again. They verified that the care plan indicated that the resident had a preferred bed time. When the Inspector indicated that the resident remained awake in bed, the PSW stated that the resident was no longer communicating therefore they had to "guess" their needs.

On July 11, 2017, at 1020 hours, during an interview with the Inspector, PSW #107 stated that the resident had been provided with care and that they had cleaned the resident's mouth with a toothette, but stated that they had forgotten to provide support with other ADLs.

During an interview with the Inspector, the DOC stated that care should have been provided as per the care plan. It was not acceptable to put a resident to bed for the convenience of staff. They confirmed that the resident's care had not been provided to them as per the plan of care. [s. 6. (7)]

4. Resident #002 was identified from their most recent Minimum Data Set (MDS) Assessment as having a new fracture, as well as a fall in the last 30 days.

A CI report was also submitted to the Director in June, 2017, related to the health status of resident #002. According to the CI report, resident #002 entered resident #019's room and was pushed, resident #002 fell and sustained an injury.

Inspector #543 reviewed resident #002's health care record, specifically progress notes related to the fall that occurred in June 2017. This progress note described that the resident was found in the hallway in front of another resident's room. Another progress note dated a few days later, described that the resident had another fall; whereby, the resident was found lying on the floor in their room. This progress note indicated that fall interventions had not been implemented.

Inspector #543 reviewed resident #002's Team Conference Assessment, that was conducted in June 2017. This assessment identified specific interventions related to falls.

Inspector #543 reviewed this resident's most recent care plan, which indicated that

the resident had a potential for injury related to falls. The resident's care plan identified specific interventions related to falls.

On July 11, 2017, Inspector #543 observed resident #002 in the dining room, in a chair with an assistive device on.

On July 11, 2017, Inspector #543 observed resident #002 resting in their bed, the fall intervention had not been implemented correctly.

On July 11, 2017, Inspector #543 interviewed RPN #114, who verified that since resident #002 fell and sustained an injury, that resident #002 should have had the fall interventions in place when they fell again a few days later.

On July 11, 2017, Inspector #543 interviewed PSW #137 who stated that the resident should have fall interventions implemented at all times, even when in bed.

On July 11, 2017, Inspector #543 interviewed PSW #120 (this resident's regular PSW) who verified that since the fall they have implemented specific fall interventions at all times.

On July 13, 2017, Inspector #543 interviewed PSW #138 who verified that resident #002 required specific interventions implemented at all times.

On July 13, 2017, Inspector #543 interviewed RN #139 who confirmed that resident #002 had returned from the hospital, in June 2017. RN #139 verified that the resident did not have the fall interventions implemented at the time of the fall. [s. 6. (7)]

5. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #007 was identified from their previous to most recent MDS assessment as having a new fracture in the last 180 days.

Inspector #543 reviewed the resident's health care record, specifically progress notes from May 2017, which indicated that x-rays identified a specific injury.

The Inspector reviewed the resident's most recent care plan, specifically related to

their injury, which identified that staff were to ensure an assistive device to the injured area.

On July 12, 2017, Inspector #543 observed resident #007, without the assistive device to the injured area.

On July 12, 2017, Inspector #543 interviewed PSW #103, who verified that resident #007 still required the assistive device to the injured area.

On July 12, 2017, Inspector #543 interviewed RPN #114 who stated that the resident no longer required the assistive device to the injured area.

On July 12, 2017, Inspector #543 interviewed RN #118 regarding the resident requiring an assistive device to the injured area. They stated the resident no longer required the device and was only implemented as a nursing intervention. The Inspector informed the RN that this resident's care plan indicated to ensure that the assistive device was in place. The RN verified that the care plan should have been updated. [s. 6. (10) (b)]

6. Resident #002 was identified from their most recent MDS Assessment as having a new fracture, as well as a fall in the last 30 days.

A CI report was submitted to the Director in June 2017. According to the CI report, resident #002 entered another resident's room and was pushed, fell and sustained an injury.

Inspector #543 reviewed resident #002's most recent care plan, which identified that staff would implement specific interventions related to falls. This plan also indicated that staff would ensure that the resident's environment was safe while wandering.

On July 11, 13, and 14, 2017, Inspector #543 observed resident #002 in various areas of the home area. The resident was observed on all three days sitting in a chair.

During an interview with Inspector #543, PSW #114 and #137 indicated that resident was no longer able to ambulate and used an assistive device since the fall in June 2017.

On July 13, 2017, Inspector #543 interviewed RN #139, who verified that resident #002 was no longer able to ambulate. The inspector indicated that the resident's care plan identified that the resident could wander freely within their home area. RN #139 stated that the resident was no longer capable of ambulating and the care plan should have been updated. [s. 6. (10) (b)]

7. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least very six months and at any other time when, the care set out in the plan has not been effective.

A CI report was submitted to the Director in February 2016. According to the CI report, resident #014 was found lying on the floor, unable to tell staff what had happened. The resident was complaining of pain and had an injury. The CI report also identified that the resident had a history of falling. The resident was sent to the hospital for assessment and returned to the home palliative. Resident #014 passed away.

Inspector #543 reviewed resident #014’s health care record. Their progress notes identified the resident fell a number of times between October 2015 and February 2016.

Inspector #543 reviewed this resident's care plan in place at the time, which indicated that resident #014 had a potential for injury related to falls and identified specific interventions. No new intervention were implemented for this resident related to the falls that occurred between on January and February 2016.

Inspector #543 reviewed resident #014’s two Morse Fall Scale Assessments, completed in January 2016, which determined the resident to be a high risk for falls.

Inspector #543 reviewed the home's policy titled "Falls Prevention and Management Program" with a revision dated of May 04, 2017. This policy indicated that registered staff would initiate an Interprofessional Team review if a resident had two or more falls in 72 hours, or three or more falls in three months. The policy identified that the Interprofessional Team would conduct a review to determine the possible cause(s) of falls and develop additional strategies to prevent reoccurrence, if falls were occurring repeatedly, and address resident specific needs in revising the plan of care.

Resident #014's Death Certificate, indicated the cause of death was the result of an injury from a fall.

On July 14, 2017, Inspector #543 interviewed RN #118 about resident #014's care plan, indicating that there were no new interventions implemented after the resident's falls that occurred in January and February 2016. The RN responded that it was likely due to the fact that this resident was capable of making their own decisions and would not follow instructions. [s. 6. (10) (c)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #008's plan of care provides clear directions to staff and others who provide direct care to the resident; and resident #008's SDM is provided the opportunity to participate fully in the development and implementation of their plan of care, and that residents are reassessed and the plan of care reviewed and revised at least very six months and at any other time when, the care set out in the plan has not been affective, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A CI report was submitted to the Director in April 2016, alleging that resident to resident sexual abuse may have occurred between resident #010 and #011. It was alleged that resident #011 spoke to and touched resident #010 in an inappropriate sexual manner.

Inspector #627 reviewed the CI report which identified that the incident had occurred on a day in April 2016. The CI report described that RN #118 and RPN #101 witnessed the incident of alleged sexual abuse that was not reported to the Director until almost 30 hours later.

A review of the home’s policy titled "Zero Tolerance for Abuse and Neglect", last reviewed September 2016, described sexual abuse as any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member. The policy further indicated that any employee or volunteer who witnessed, or became aware of, or suspected abuse were to report it immediately to the Director of Care/Administrator/delegate (e.g. RN in charge during off hours), who ensured that a thorough and confidential investigation was initiated.

During an interview with the Inspector, RN #118 stated that resident #011 had often demonstrated sexually responsive behaviours towards staff. At the time of the incident, they had failed to recognize it as abuse. They stated that the home’s policy identified sexual abuse as any non-consensual touching or remarks of a sexual nature and that they should have reported the incident right away to the DOC or ADOC.

During an interview with the Inspector, the DOC stated that the staff member had not immediately recognized the incidence as abuse. When the DOC became aware of the incident, they proceeded to report it immediately, and investigated it. The DOC confirmed that the staff member had failed to report it immediately. [s. 20. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident of alleged abuse was immediately reported to the Director.

A CI report, was submitted to the Director in June 2017, related to alleged staff to resident abuse. According to the CI report, PSW #124 had provided inappropriate care that resulted in risk of harm to resident #006 and resident #017, on a specific day in June 2017.

Inspector #642 reviewed resident #006 and #017's progress notes, which identified that in June 2017, the Administrator identified that two incidents of inappropriate care that resulted in risk of harm to the resident may have occurred on a specific day in June 2017, and that the incidents were being investigated.

The Inspector reviewed the home's internal investigation notes and a letter submitted to the ADOC related to the incident of alleged abuse. The letter identified that PSW #124 spoke to resident #006 in a rude and unprofessional manner. The letter identified that resident #006 had indicated several times that PSW #124, was being inappropriate. This letter also described an incident where PSW #124 was verbally inappropriate towards resident #017.

Inspector #642 reviewed the home's "Zero Tolerance for Abuse and Neglect" policy last reviewed, September 29, 2016. Under Appendix C-LTCHA Mandatory Reports; reporting certain matters to Director 24. (1) "A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director."

Inspector #642 interviewed PSW #124 on July 07, 2017, who stated that the alleged incident of abuse related to inappropriate care for residents #006 and #017 occurred on a day in June, 2017.

Inspector interviewed the ADOC on July 10, 2017, who stated that the alleged incident of inappropriate care was reported to them in June 2017, and it was not reported to the Director until the following day. [s. 24. (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 that any incident of alleged abuse is immediately reported to the Director, to be implemented voluntarily.

WN #5: 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. The licensee has failed to ensure 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 intervals provided for in the regulations:
1. Abuse recognition and prevention and
6. Any other areas provided for in the regulations.

1. A CI report was submitted to the Director in February, 2016. According to the CI report, resident #014 was found lying on the floor, unable to tell staff what had happened. The resident was complaining of pain and had an injury. The CI report also identified that the resident had a history of falling. The resident was sent to the hospital for assessment and returned to the home palliative. The resident passed away.

Inspectors #543 reviewed the education/training documents provided related to the home's Falls Prevention and Management Program which indicated that 35 per cent of direct care staff had not completed the training for the year 2016.

Inspector #543 interviewed the DOC, regarding the training provided related to the home's Falls Prevention and Management Program. The DOC verified that not all staff who provided direct care to residents completed the training for the year 2016.

2. A CI report was submitted to the Director in April, 2016, alleging resident to resident sexual abuse between resident #010 and #011. It was alleged that resident #011 spoke and touched resident #010 in an inappropriate sexual manner.

Inspector #627 reviewed the education/training documents provided related to the home's Zero Tolerance for Abuse and Neglect policy which indicated that 9.7 per cent of staff had not completed the training.

Inspector #627 interviewed the DOC who verified that not all staff had completed the annual training related to the home's Zero Tolerance for Abuse and Neglect policy. [s. 76. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure 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 identified paragraphs, at times or intervals provided for in the regulations, related to abuse recognition and prevention and any other areas provided for in the regulations, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On July 07, 2017, during a family interview with resident #008's family member, they informed Inspector #627 that they had concerns regarding the cleanliness of the resident's room. They stated that in June, 2017, they had informed PSW #110 that there were dirty marks on the wall in the resident's room. The family member showed Inspector #627 a picture of the dirty marks on the wall. The family member

approached the cleaning staff as the marks remained on the wall and asked for the marks to be cleaned from the wall. The cleaning staff proceeded to wash the wall with the floor mop. The family member pointed out to the Inspector that the dirty marks remained on the wall after the cleaning staff had wiped it down with a mop.

On July 07, 2017, Inspector #627 noted dirty marks on the wall were, 2.5 to 5 centimeters above a base board. The two dirty marks were approximately 2.5 to 4 centimeters in diameter.

On July 11, 2017, at 1530 hours, during an interview with PSW #120 in resident #002's room, Inspector #543 noted dirt on the floor next to resident's bed. The PSW noticed it as well, and wiped it up with a cloth. The dirt was dried to the floor and PSW #120 had some difficulty wiping it up.

On July 07, 2017, during an interview with Inspector #627, housekeeping staff #106 stated that it was reported that there was dirt on the wall or on the floor by a PCA, they would use their mop to clean, as there was a disinfectant in the water. They stated to the Inspector that they had cleaned the dirty marks off the wall when the family had reported it to them. They further stated that they would clean the remaining dirt right away.

Inspector #627 interviewed the Environmental Service Manager who stated that a specific cleaning policy, with a revision date of July 21, 2016, was followed for cleaning dirt on the walls or on the floor. During the daytime hours, the housekeeping staff would be responsible for the cleaning, and on evenings and night shift, the PSWs would be responsible for the cleaning. They stated that it was not acceptable to wait for the next day to clean dirt off the wall and floors. The cleaner used for mopping the floor was a general disinfectant to be used daily and should not be used to clean dirt. They further stated that the dirt on the wall should not have been cleaned with the mop.

Inspector #627 interviewed the DOC who stated that if there was visible dirty marks in a resident's room, it would be cleaned right away, during the day by the housekeeping staff, and during the evening by the PSWs. [s. 15. (2) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse.

A CI report was submitted to the Director in April 2016, alleging resident to resident sexual abuse between resident #010 and #011. It was alleged that resident #011 spoke to and touched resident #010 in an inappropriate sexual manner.

Inspector #627 reviewed the CI report which identified that the incident had occurred on a specific day in April 2016. The CI report described that RN #118 and RPN #101 witnessed an incident of alleged sexual abuse. A review of resident #010's progress notes identified that the resident's spouse was notified of the incident during a meeting with the DOC and the Social Worker, 27 hours after the incident.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect", last reviewed September 29, 2016, revealed "the substitute decision maker (SDM), if any, or any other person specified by the resident must be notified within 12 hours of becoming aware of the incident of abuse/neglect.

During an interview with the Inspector, RN #118 stated that they had not recognized the incident as abuse. They stated that the home's policy identified sexual abuse as any non-consensual touching or remarks of a sexual nature and that they should have reported the incident right away to the DOC or ADOC.

During an interview with the Inspector, the DOC stated that the incident had only been reported to the SDM on a day in April 2016, when they became aware of the incident which was more than 24 hours later. [s. 97. (1) (b)]

Issued on this 7 day of November 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543) - (A1)

Inspection No. / No de l'inspection : 2017_668543_0004 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 003891-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Nov 07, 2017;(A1)

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

LTC Home / Foyer de SLD : ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Ray Ingriselli

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all direct care staff initiate Inter-professional Team Reviews/Team Conferences as indicated in the home's "Falls Prevention and Management Program", and deliver any other care to residents as specified in the policy.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A Critical Incident (CI) report was submitted to the Director in February 2016. According to the CI report, resident #014 was found lying on the floor and unable to tell staff what had happened. The resident was complaining of pain and had an injury. The CI report also identified that the resident had a history of falling. The resident was sent to the hospital for assessment and returned to the home palliative. Resident #014 passed away.

Inspector #543 reviewed the home's policy titled "Falls Prevention and Management Program" with a revision date of May 4, 2017. This policy indicated that registered

staff would initiate an inter-professional team review if a resident had two or more falls in 72 hours, or three or more falls in three months.

Inspector #543 reviewed resident #014's health care record and identified that this resident had fallen on specific dates in January and February 2017, having had three or more falls in less then three months. The Inspector was unable to identify that any Inter-professional Team Review/Team Conference was held to address this resident's falls.

Inspector #543 interviewed RN #118 regarding the Inter-professional Team Reviews/Team Conferences that were to be held post falls for residents. The RN verified that the policy "Falls Prevention and Management Program", which outlined the frequency of falls a resident had that would initiate an Inter-professional Team Review/Team Conference was accurate. The RN and the Inspector went through resident #014's health care record (care plan, progress notes and assessments) together, which indicated that no Inter-professional Team Reviews/Team Conferences were held for this resident for the falls that occurred on specific dates in January and February 2017.

On July 14, 2017, Inspector #543 interviewed the DOC, regarding the Inter-professional Team Reviews/Team Conferences that were to be held post falls for residents. The Inspector indicated that they had read in the home's Falls policy that it was required that those reviews were to be held if a resident fell two times (or more) in a 72 hour period or three times (or more) in a 3 month period. The DOC verified that was accurate and should happen for each resident who had numerous falls. The Inspector shared with the DOC that for resident #014 there were none of the reviews completed for this resident for the falls that occurred on specific dates in January and February 2017. The DOC verified that no Inter-professional Team Reviews/Team Conferences were completed. [s. 8. (1) (a),s. 8. (1) (b)]

The decision to issue a compliance order was based on actual harm to residents health and safety, the home continues to have on-going non-compliance related to this area of the legislation. There was a history of previous non-compliance identified during the following inspections: Voluntary Plan of Corrections were left for the following inspections: #2015_264609_0059, and #2015_380593_0015 and 2014_332575_0014. (543)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

Nov 30, 2017(A1)

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Develop and implement a process to ensure that for residents #002 and #008 the care set out in the plan of care is provided as specified in the plan,

b) Develop and implement a process to ensure that all direct care staff involved in the care of residents in the home, review the residents' plans of care and are kept aware of every residents' most up to date plans of care as changes occur.

Grounds / Motifs :

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

During a family interview with Inspector #627, resident #008's SDM stated that they had concerns regarding the resident not being provided with specific care. Also, the SDM stated that the resident was often put to bed too early, although their care plan identified that the resident preferred going to bed later. The SDM stated that they had been told by the staff that the resident had to be in bed prior to them having their supper break, which was before the resident's preferred bed time, if they wanted assistance from a co-worker.

On July 06, 2017, at 1345 hours, Inspector #627 observed resident #008 in bed. The resident had dried food on their chin and in the corners of their mouth.

On July 10, 2017, at 1000 hours, Inspector #627 observed resident #008 in their room. The resident was not wearing their top denture. A dry electric toothbrush was observed on the resident's night table.

On July 10, 2017, at 1830 hours, Inspector #627 observed the resident in bed prior to their preferred bed time.

On July 11, 2017, at 0910 hours, the resident was observed in the dining room.The resident was not wearing their glasses.

The Inspector reviewed resident #008's care plan in effect at the time of the inspection and noted specific interventions related to specific care and ADLs, which were not consistent with what was observed.

On July 10, 2017, at 1000 hours, during an interview with Inspector #627, PSW #104 stated that the resident had received morning care, however, they had not had their dentures put in, nor had they received mouth care. The PSW stated that they were short staffed, and had not had the time to complete mouth care.

On July 10, 2017, at 1840 hours, during an interview with Inspector #627, PSW #110 stated that the resident had been put to bed between 1815 hours and 1825 hours. They stated that the resident had required assistance with specific ADLs and was then transferred to bed. They further stated that typically, when a resident was transferred to bed after supper, staff did not get them up again. They verified that the care plan indicated that the resident had a preferred bed time. When the Inspector indicated that the resident remained awake in bed, the PSW stated that the resident

was no longer communicating therefore they had to "guess" their needs.

On July 11, 2017, at 1020 hours, during an interview with the Inspector, PSW #107 stated that the resident had been provided with care and that they had cleaned the resident's mouth with a toothette, but stated that they had forgotten to provide support with other ADLs.

During an interview with the Inspector, the DOC stated that care should have been provided as per the care plan. It was not acceptable to put a resident to bed for the convenience of staff. They confirmed that the resident's care had not been provided to them as per the plan of care. [s. 6. (7)]

2. Resident #002 was identified from their most recent Minimum Data Set (MDS) Assessment as having a new fracture, as well as a fall in the last 30 days.

A CI report was also submitted to the Director in June, 2017, related to the health status of resident #002. According to the CI report, resident #002 entered resident #019's room and was pushed, resident #002 fell and sustained an injury.

Inspector #543 reviewed resident #002's health care record, specifically progress notes related to the fall that occurred in June 2017. This progress note described that the resident was found in the hallway in front of another resident's room. Another progress note dated a few days later, described that the resident had another fall; whereby, the resident was found lying on the floor in their room. This progress note indicated that fall interventions had not been implemented.

Inspector #543 reviewed resident #002's Team Conference Assessment, that was conducted in June 2017. This assessment identified specific interventions related to falls.

Inspector #543 reviewed this resident's most recent care plan, which indicated that the resident had a potential for injury related to falls. The resident's care plan identified specific interventions related to falls.

On July 11, 2017, Inspector #543 observed resident #002 in the dining room, in a chair with an assistive device on.

On July 11, 2017, Inspector #543 observed resident #002 resting in their bed, the fall

intervention had not been implemented correctly.

On July 11, 2017, Inspector #543 interviewed RPN #114, who verified that since resident #002 fell and sustained an injury, that resident #002 should have had the fall interventions in place when they fell again a few days later.

On July 11, 2017, Inspector #543 interviewed PSW #137 who stated that the resident should have fall interventions implemented at all times, even when in bed.

On July 11, 2017, Inspector #543 interviewed PSW #120 (this resident's regular PSW) who verified that since the fall they have implemented specific fall interventions at all times.

On July 13, 2017, Inspector #543 interviewed PSW #138 who verified that resident #002 required specific interventions implemented at all times.

On July 13, 2017, Inspector #543 interviewed RN #139 who confirmed that resident #002 had returned from the hospital, in June 2017. RN #139 verified that the resident did not have the fall interventions implemented at the time of the fall. [s. 6. (7)]

The decision to issue a compliance order was based on the potential for actual harm to residents #002 and #008's health and safety. The scope was determined to be a pattern and the home continues to have on-going non-compliance related to this area of the legislation. There was a history of previous non-compliance identified during the following inspections: #2016_320612_0007 a VPC, #2015_282543_0023 a VPC and #2015_380593_0015 a Written Notification.

(543)

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

Nov 30, 2017(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall:

a) Ensure that all residents are reassessed and their plan of care is reviewed and revised whenever the residents' care needs change or care set out in the plan is no longer necessary,

b) Develop and implement a monitoring system to ensure that when residents' needs change that they are reassessed, their plans of care are revised, that staff are aware of the changes and provide care to the resident as specified in the plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #007 was identified from their previous to most recent MDS assessment as

having a new fracture in the last 180 days.

Inspector #543 reviewed the resident's health care record, specifically progress notes from May 2017, which indicated that x-rays identified a specific injury.

The Inspector reviewed the resident's most recent care plan, specifically related to their injury, which identified that staff were to ensure an assistive device to the injured area.

On July 12, 2017, Inspector #543 observed resident #007, without the assistive device to the injured area.

On July 12, 2017, Inspector #543 interviewed PSW #103, who verified that resident #007 still required the assistive device to the injured area.

On July 12, 2017, Inspector #543 interviewed RPN #114 who stated that the resident no longer required the assistive device to the injured area.

On July 12, 2017, Inspector #543 interviewed RN #118 regarding the resident requiring an assistive device to the injured area. They stated the resident no longer required the device and was only implemented as a nursing intervention. The Inspector informed the RN that this resident's care plan indicated to ensure that the assistive device was in place. The RN verified that the care plan should have been updated. [s. 6. (10) (b)]

2. Resident #002 was identified from their most recent MDS Assessment as having a new fracture, as well as a fall in the last 30 days.

A CI report was submitted to the Director in June 2017. According to the CI report, resident #002 entered another resident’s room and was pushed, fell and sustained an injury.

Inspector #543 reviewed resident #002’s most recent care plan, which identified that staff would implement specific interventions related to falls. This plan also indicated that staff would ensure that the resident's environment was safe while wandering.

On July 11, 13, and 14, 2017, Inspector #543 observed resident #002 in various areas of the home area. The resident was observed on all three days sitting in a

chair.

During an interview with Inspector #543, PSW #114 and #137 indicated that resident was no longer able to ambulate and used an assistive device since the fall in June 2017.

On July 13, 2017, Inspector #543 interviewed RN #139, who verified that resident #002 was no longer able to ambulate. The inspector indicated that the resident's care plan identified that the resident could wander freely within their home area. RN #139 stated that the resident was no longer capable of ambulating and the care plan should have been updated. [s. 6. (10) (b)]

The decision to issue a compliance order was based on the potential for actual harm to residents #002 and #007's health and safety. The scope was determined to be a pattern and the home continues to have on-going non-compliance related to this area of the legislation. There was a history of previous non-compliance identified during the following inspections: #2016_320612_0007 a VPC, #2015_380593_0015 a WN and 20014_282543_0029 a VPC.

(543)

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

Nov 30, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

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

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

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

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

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

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

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

Issued on this 7 day of November 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TIFFANY BOUCHER - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Sudbury