Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2013	2013_140158_0007	S-0110-13, S-0049-13	Critical Incident System

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

---

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 25, 26, 29, 2013

Log # S-0049-13, Log # S-0110-13

During the course of the inspection, the inspector(s) spoke with the Site Manager (administrator), VP Clinical Services, Director of Care (DOC), Registered staff (RN/RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk throughout resident care areas and various common areas, observed interactions between residents and staff, reviewed the health care record of the residents identified in the mandatory report and critical incident report, and reviewed the home's Abuse, Falls and Continence policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

s. 6. (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 did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
A Critical Incident (CI) was reported to the Director identifying that Resident # 01 fell four times in April 2013. The Inspector noted that the resident had three additional falls post CI report.
Resident # 01 plan of care identified interventions such as ensuring the bed is in its lowest position, ensuring that the hip protectors are worn, ensuring commonly used articles are within reach, and that the call bell is within reach.
The Inspector observed that resident # 01 was very unsteady as they stood by their comfy chair at 1020hr on April 26/13. The resident attempted to walk to the wheel chair (w/c) which was not within reach. The w/c was brought closer to the resident who was then assisted into the w/c by the Inspector. The resident then propelled themself to the bathroom where they attempted to transfer unassisted onto the toilet.
The resident was wearing a brief and did not have any hip protectors on. The Inspector also observed that the bed was not in its lowest position and that the resident's call bell was tucked between the cushions of the resident's comfy chair.
The licensee did not ensure that the care set out in the plan of care was provided to resident # 01 as specified in the plan. [s. 6. (7)]
2. The licensee did not ensure that the resident is reassessed and that the plan of care reviewed and revised at least every six months and at any other time when (b) the resident's care needs changed.
A Critical Incident was reported to the Director identifying that resident # 01 had fallen four times in April 2013. At the time of this inspection, the resident had fallen an additional three times.
A review of resident # 01 health care record showed that resident # 01 had an indwelling catheter when admitted in February 2013. The catheter was removed in March 2013.
There were several entries in the progress notes after resident # 01 returned from hospital identifying resident # 01 increased periods of urinary incontinence as well as the staff's use of various coloured briefs to manage the resident's incontinence.
A readmission assessment was documented in the progress notes by staff # 110 when resident # 01returned from hospital; however this assessment failed to

identify the resident's change in urinary status or any interventions to use. A continence assessment using a specific tool which identifies the resident's state of continence and the interventions to manage the periods of incontinence was not found.
Resident # 01 care plan was reviewed by the Inspector and identified the resident's potential for incontinence post removal of the catheter and the use of pads. The care plan however is not reflective of the resident's current state of continence or interventions used to manage his incontinence.
The licensee did not ensure that resident # 01 was reassessed and that the plan of care 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 to ensure that care set out in the plan of care is provided to resident # 01 as specified in the plan and that a continence assessment is completed for resident # 01 which will identify interventions to manage their incontinence and prevent further falls, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. Every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents that contains an explanation of the duty under section 24 to make mandatory reports.
Inspector reviewed the Policy titled "Resident Abuse" which identifies that "any employee who witnesses or becomes aware of or suspects resident abuse shall report it immediately to the Registered Staff/Director of Care/Administrator who will conduct a thorough and confidential investigation. It is also documented in the policy under Reporting and Notifications that " Section 24 (1) of the LTCHA requires certain persons, including the facility and certain staff members to make immediate reports to the Director ". However, LTCHA 2007, S.O. 2007, c.8, s. 24 (1) states that "a person who has reasonable grounds to suspect... shall immediately report the suspicion to the Director". Although the home's Abuse Policy contains an explanation of the duty under section 24 to make mandatory reports, the information in the policy is not correct. The home's written policy to promote zero tolerence of abuse does not meet all requirements. [s. 20. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerence of abuse meets all requirements, specifically the explanation of the duty under section 24 for " a person who has reasonable grounds to suspect abuse of a resident to immediately report the suspicion", to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The home did not ensure that, each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.
The home's continence care program procedures identify that residents are assessed for bladder and bowel continence upon admission, quarterly, and when there is a change in the resident that may affect continence.
The health care records of eight residents who are incontinent were reviewed by the Inspector.
A quarterly continence assessment, using a clinically appropriate assessment instrument was not found completed for five of eight residents. There were no continence assessments completed for three of eight residents.
Although there are designated staff on the units who are to assess the resident's need of a product, the Inspector observed staff # 103, who is not part of the continence care committee, change the type of product a resident was using without reassessing the resident with a specifically designed assessment tool, stating resident # 10 "does not need a day brief now".
The home did not ensure that, eight residents who are incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence. [s. 51. (2) (a)]

2. The licensee did not ensure that residents are provided with a range of continence care products that,(i)are based on their individual assessed needs,(ii) properly fit the residents,(iii) promote resident comfort, ease of use, dignity and good skin integrity,(iv) promote continued independence wherever possible, and (v) are appropriate for the

time of day, and for the individual resident's type of incontinence.
The Inspector observed that only pads/liners and briefs are available in the home and are provided to the residents. The Inspector spoke with Staff # S-106, # S-107, # S-108 who confirmed this.
A review of the resident's "Continence list" identified that resident # 01, # 04, # 05, # 06, # 07, # 08 and # 09, who are incontinent, wear "pull ups", which are supplied by the family.
The company which supplies the home its continence products was in to assess residents in November 2012 and in 2013. There was no continence assessments found completed for the residents identified as wearing "pull ups".
Staff # 103 identified in resident # 01 progress notes that the resident had difficulty with using a brief, was embarrassed and would not wear the product. It was also noted that resident # 01 had impaired skin integrity in the perineal area.
Staff # S-106 and Staff # 107 told the Inspector that resident # 06 and resident # 07 expressed their embarrassment with wearing a brief.
The DOC identified that the home previously supplied "pull ups", however, only briefs and pads/liners are now supplied.
A range of continence care products that are based on resident's need, that promote resident comfort, ease of use, dignity and promote good skin integrity are not provided to residents. [s. 51. (2) (h)]

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 where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence and that all residents are provided with a range of continence care products that are based on their individual assessed needs, that properly fit the residents, that promote resident comfort, ease of use, dignity and good skin integrity, that promote continued independence wherever possible, and that are appropriate for the time of day, and for the individual resident's type of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director.

The Inspector noted that a written letter of complaint from the family of resident # 02 related to the care of the resident was filed in the resident's health care record. The letter identified the family's complaint of the home's lack of attentiveness and concern regarding resident # 02 physical health condition. The letter further states that this lack of attentiveness/concern has caused the resident further grief. The DOC confirmed that the written complaint was filed by front line staff in the resident's health care record and not reported to management. This written complaint was not immediately forward to the Director. [s. 22. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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, ss. 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, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 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, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm was not immediately reported to the Director.
An incident of resident to resident physical abuse occurred in February 2013. One resident sustained an injury as a result.
Although a critical incident was submitted the day after the incident, the incident was not reported immediately to the Director. [s. 24. (1)]

WN #6: 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 did not ensure that, (a)drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies.
On April 29, 2013, the Inspector observed that a medicated cream was left on resident # 02 bedside table. A current order for the cream was found however there was no order for self use or to leave at the bedside. On April 29, 2013, the Inspector observed that two medicated creams were found in resident # 01 bathroom cupboard. Although there was a current order for one of the creams, the second cream was discontinued. There was no order to leave the medicated cream at the bedside or for self use. The licensee did not ensure that resident # 01 and resident # 02 medicated creams were stored in an area or medication cart that is exclusively for drugs and drug related supplies. [s. 129. (1) (a) (i)]

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

Issued on this 8th day of May, 2013

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