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 soins 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
Dec 19, 2016	2016_395613_0016	026786-16	Resident Quality Inspection

Licensee/Titulaire de permis

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

Algoma Manor Nursing Home
145 Dawson Street THESSALON ON P0R 1L0

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

LISA MOORE (613), AMY GEAUVREAU (642), CHAD CAMPS (609), JENNIFER LAURICELLA (542)

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): September 19 - 23 and 26 - 30, 2016

Additional logs inspected during this RQI include:
Three critical incident reports submitted by the home related to resident to resident abuse;
One critical incident report submitted by the home related to a resident fall;
One complaint related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Pharmacist, Office Manager, Scheduler, Restorative Care, Bayshore Physiotherapist, Maintenance, Registered Nurses (RNs and RPNs), Resident Assessment Instrument Coordinator (RAI Coordinator), Personal Support Workers (PSWs), residents and family members.

During the course of the Resident Quality Inspection, the Inspectors conducted a daily walk through of the resident home areas and various common areas, made direct observation of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed health care records and various policies, procedures and programs of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **8 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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

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 there was a written plan of care for each resident that set out the planned care for the resident.

Inspector #542 reviewed a Critical Incident Report (CI) that was submitted to the Director in May 2016. The CI report indicated that resident #004 sustained an injury after a fall.

On September 27, 2016, the Inspector observed resident #004 to be seated in their wheelchair with a device in place and activated.

The Inspector completed a health care record review for resident #004. The current care plan indicated care plan indicated resident #004's risk levels for falls; however, the care plan did not include the use of a wheelchair device or a bed device.

On September 27, 2016, Inspector #542 interviewed PSW #108, who indicated that resident #004 had a wheelchair device and a bed device that were used as fall prevention interventions.

On September 28, 2016, the Inspector interviewed RPN #106, who verified that resident #004 had a wheelchair and bed device used as fall prevention interventions. They also indicated that these interventions should have been on the current care plan. On the same date, the Inspector interviewed Restorative Care staff #115 and Physiotherapist staff # 116, who were part of the Falls Prevention and Management Program, they verified that all falls prevention interventions were to be included in the resident's current care plan. [s. 6. (1) (a)]

2. 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.

Inspector #642 reviewed a Critical Incident Report (CI) that was submitted to the Director in June 2016. The CI report described an incident in June 2016, where resident #017 exhibited a specific responsive towards resident #002, which resulted in injuries to resident #002.

A review of the home's internal investigation revealed that resident #002 had wandered into resident #017's room, which triggered the responsive behaviour incident.

A review of resident #002's plan of care, dated June 2016, indicated that a bed device was to have been applied to the resident's bed throughout the night to alert staff when resident #002 wandered and prevent the resident from wandering into other residents' rooms.

On September 28, 2016, the Inspector interviewed the Director of Care (DOC), who stated on the morning of the incident, June 2016, the staff started their morning care down at the other end of the hallway, away from resident #002's room. The DOC verified that no morning care had been provided to the resident before the incident had occurred. As well, the DOC confirmed that it was their expectation that the bed device should have been applied and on during the time of the incident.

A further review of the home's internal investigation found that no bed device was applied at the time of the incident in June 2016.

During interviews with RPN #113 and PSW #100 in September 2016, both stated that they were present and working on the morning of June 2106, and were the first to find resident #002 after the responsive behaviour incident. RPN #113 and PSW #100 verified that resident #002's bed device had not been applied.

During an interview with the DOC in September 2016, they stated that care set out in the plan of care should be provided to the resident as specified in the plan. The DOC verified the bed device had not been applied to resident #002's bed during the morning of June 2016. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident’s care needs changed or care set out in the plan was no longer necessary.

Inspector #642 reviewed a CI report that was submitted to the Director in June 2016. The CI report described an incident in June 2016, whereby resident #017 exhibited specific responsive towards resident #002 which resulted in injuries to resident #002.

A review the home’s internal investigation revealed that resident #002 had wandered into resident #017’s room, which triggered resident #017’s physically responsive behaviour.

A review of resident #002’s plan of care, which had been updated in June 2016, the day of this incident, indicated that the bed device was to have been applied to the resident’s bed at all times to alert staff to the resident's wandering and fall risks.

During interviews with PSW #110 and PSW #111 in September 2016, they both stated that resident #002's bed device was discontinued and that a door device was now being used.

During an interview with RN #107 in September 2016, they reviewed resident #002’s plan of care and stated that resident #002 was to have their bed device on at all times for their specific behaviour.

In September 2016, the Inspector observed resident #002’s room and found no bed device.

During the same interview with RN #107 in September 2016, they verified that the bed device had been removed and replaced with a door device approximately two months ago and that the plan of care had not been revised to reflect this.

During an interview with the DOC in September 2016, they verified that the long standing change in resident #002’s care from a bed device to a door device should have been

revised in the resident's plan of care in July 2016 when the door device was received. [s. 6. (10) (b)]

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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of health conditions, including risk of falls and other special needs.

During stage one of the RQI, resident #006 was identified to have had a fall in the last 30 days.

Inspector #542 completed a health care record review for resident #006. The current care plan indicated resident #006's risk levels for falls. Interventions were listed to assist staff in managing resident #006's risk for falls.

On September 28, 2016, Inspector #542 interviewed Restorative Care staff #115 and Physiotherapist staff # 116, who were part of the Falls Prevention and Management Program. They were also part of the assessment process for indicating additional interventions to decrease risk for falls for the residents. They indicated that for resident #006, they developed additional interventions to address the resident's risk for falls.

The Inspector reviewed the current care plan with both staff members, who both verified that these interventions were not on the resident's care plan. [s. 26. (3) 10.]

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 resident #006's plan of care is based on an interdisciplinary assessment of special treatments and interventions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

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 at least annually, the matters referred to in subsection (1) regarding responsive behaviours were evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

On September 29th, 2016, Inspector #542 interviewed the DOC, who was also the lead for the Responsive Behaviour Program. The Inspector asked the DOC if in regards to responsive behaviours, the written approaches, written strategies, resident monitoring and internal reporting protocols and the protocols for the referral of residents to specialized resources when required, were evaluated annually and updated in accordance with evidence-based practices or prevailing practices. The DOC verified that the home did not have any evidence to support that the the written approaches, written strategies, resident monitoring and internal reporting protocols and the protocols for the referral of residents to specialized resources when required was evaluated in 2015 and that it had not yet been evaluated for 2016. [s. 53. (3) (b)]

2. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, the behaviour triggers for the resident were identified, where possible.

Inspector #642 reviewed a CI that was submitted to the Director in September 2016, which described a physically responsive incident, whereby, resident #013 displayed a specific responsive behaviour towards resident #014.

The Inspector reviewed two other physically responsive behaviour incidents involving resident #013. In June 2016, the resident became physically responsive towards another resident in a common room and in July 2016, the resident became physically responsive in a tub room towards staff.

On September 30, 2016, the Inspector interviewed RPN #120 and PSW #119, who stated that resident #014 was a trigger for resident #013's physically responsive behaviours and that resident #013 could be physically responsive to individual residents and staff members in common areas of the home.

A review of the home's policy titled, "Responsive Behaviours Management #VII-F-10.20" last revised January 2015, indicated that behavioural triggers were to be identified for every resident demonstrating responsive behaviours.

A review of resident #013's current plan of care found no physically responsive behaviour

triggers identified in the resident's plan of care related to common areas as well as the proximity of resident #014 to the resident.

During an interview with the DOC on September 30, 2016, they verified that resident #014 and common areas were triggers to resident #013's responsive behaviours and were not identified in the resident's plan of care. [s. 53. (4) (a)]

3. The licensee has failed to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs, of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Inspector #542 completed a health care record review for resident #005. The most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessment dated July 2016, included documentation that indicated that resident #005 would resist care. A review of the progress notes from June to August 2016, identified documentation that resident #005 refused care, meals and medications. The Inspector reviewed the current care plan for resident #005 which failed to identify information regarding the resident resisting and refusing care.

On September 27, 2016, Inspector #542 interviewed PSW # 108 and PSW #109, who stated that resident #005 would resist and refuse care and required persuasion from staff to complete care or attend meals.

During an interview with the DOC on September 28, 2016, who was also the lead for the Responsive Behaviour Program, they stated that they were unaware that resident #005 would often resist or refuse care and that no interdisciplinary assessment had been completed regarding their behaviours. [s. 53. (4) (c)]

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 at least annually, the matters referred to in subsection (1) regarding responsive behaviours is evaluated and updated in accordance with evidence-based practices and, if there is none, in accordance with prevailing practices. The licensee is to ensure for residents #005 and #013 demonstrating responsive behaviours, the behaviour triggers for the residents are identified, where possible and actions are taken to respond to the need of the resident, including assessments, reassessments and interventions and the residents responses to the interventions are documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that where drugs were stored access was restricted to persons who may dispense, prescribe or administer drugs in the home.

During a daily tour of the home on September 27 and 28, 2016, Inspector #609 observed a clean utility room on a unit which was locked and accessible via a keypad by staff. Inside the clean utility room was a locked medication cart with the key to the cart hanging on the wall above it. Inside the cart, topical prescription medications were found.

On September 27, 2016, Inspector #609 interviewed RN #101, who verified that PSWs as well as other staff, had access to the clean utility room and therefore the cart housing prescription topical medications. The RN stated that it was the home's practice to store prescription topical medications in the clean utility room.

A review of the home's policy titled "Medication Storage - 3.2" indicated that all medications were to be stored in a secure fashion and that these areas were to be restricted to persons who may dispense, prescribe or administer drugs in the home.

During an interview with the Pharmacist on September 28, 2016, they indicated that only registered staff were to have access to prescription medications, including prescribed topical medications.

During an interview with the DOC on September 28, 2016, they verified that it was the expectation of the home that only registered staff were to have access to prescribed medications, including prescribed topical medications and that this policy was not implemented. [s. 130. 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 where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services programs.

During stage One of the inspection, Inspector #613 interviewed the Substitute Decision Maker (SDM) for resident #004, who voiced concerns related to the levels of nursing and personal support staff in the home.

On September 22, 2016, Inspector #609 interviewed the DOC and the home's Scheduler, who were unable to provide a written staffing plan for the home's nursing and personal support services programs.

During the same interview, the DOC and the home's Scheduler verified that it was the expectation of the home that there was a written staffing plan for the nursing and personal support services programs and that the home currently did not have one. [s. 31. (2)]

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure each resident who was 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 required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

During stage one of the inspection, residents #001, #006 and #012 were identified as being incontinent.

Inspector #609 reviewed the most current incontinence assessments for resident #001 and #012 dated two different days in July 2016, which found no identification of the potential to restore function with any interventions.

The Inspector reviewed the most current incontinence assessment for resident #006 dated April 2015, which found no identification of the potential to restore function with any interventions.

During an interview with Inspector #609 on September 27, 2016, the DOC stated that the home's Bladder and Bowel Continence Assessment was the instrument used by the home to assess incontinence and that the instrument lacked the specific requirements to assess the potential for restoring function of the residents. [s. 51. (2) (a)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the copies of the inspection reports from the past two years for the long-term home were posted in the home, in a conspicuous and easily accessible location in a manner that complied with the requirements, if any, established by the regulation.

During the initial tour of the home, Inspector #613 was unable to locate the copies of the inspection reports from the past two years for the long-term care home. The Inspector noted that the only inspection report posted in the home was one dated June 6, 2016.

The missing inspection reports for the past two years were;

-Critical Incident System Inspection Report #2016_264609_0010
-Complaint Inspection Report #2016_264609_0009
-Follow Up Inspection Report #2016_264609_003
-2015 Resident Quality Inspection Report #2015_281542_0019
-Complaint Inspection Report #2015_395613_0010
-2014 Resident Quality Inspection Report #2014_211106_008

During an interview on September 28, 2016 with the DOC, they verified that the inspection reports for the past two years were not posted. As well, the DOC informed the Inspector that they were unaware that the past two years of inspection reports had to be posted. [s. 79. (3) (k)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure 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 the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff received the required annual training for mental health issues, including caring for persons with dementia, and behaviour management.

On September 29, 2016, Inspector #542 spoke with the DOC who was the lead for the home's Responsive Behaviour Program. The DOC initially indicated that the home did not have any records of training for 2015 related to Responsive Behaviours. They then provided the Inspector with an attendance sheet from August 2015 with the topic, "BSO." The DOC informed the Inspector that they were unable to determine what the specific training entailed. The attendance sheet showed that 14 out of 67 (20.9 %) of the direct care staff attended the BSO training in 2015. The DOC then provided the Inspector with training records on Dementia for 2015 which showed that 46/67 (70 %) of the direct care staff attended this training for 2015. [s. 221. (2)]

Issued on this 21st day of December, 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 soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA MOORE (613), AMY GEAUVREAU (642), CHAD CAMPS (609), JENNIFER LAURICELLA (542)
Inspection No. / No de l'inspection :	2016_395613_0016
Log No. / Registre no:	026786-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 19, 2016
Licensee / Titulaire de permis :	Algoma Manor Nursing Home 145 Dawson Street, THESSALON, ON, P0R-1L0
LTC Home / Foyer de SLD :	Algoma Manor Nursing Home 145 Dawson Street, THESSALON, ON, P0R-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pamela Ficociello

To Algoma Manor Nursing Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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 ensure that the care set out in the plan of care for resident #002 related to wandering and ineffective coping is followed.

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.

Inspector #642 reviewed a Critical Incident Report (CI) that was submitted to the Director in June 2016. The CI report described an incident in June 2016, where resident #017 exhibited a specific responsive towards resident #002, which resulted in injuries to resident #002.

A review of the home's internal investigation revealed that resident #002 had wandered into resident #017's room, which triggered the responsive behaviour incident.

A review of resident #002's plan of care, dated June 2016, indicated that a bed device was to have been applied to the resident's bed throughout the night to alert staff when resident #002 wandered and prevent the resident from wandering into other residents' rooms.

On September 28, 2016, the Inspector interviewed the Director of Care (DOC), who stated on the morning of the incident, June 2016, the staff started their morning care down at the other end of the hallway, away from resident #002's room. The DOC verified that no morning care had been provided to the resident before the incident had occurred. As well, the DOC confirmed that it was their expectation that the bed device should have been applied and on during the

time of the incident.

A further review of the home's internal investigation found that no bed device was applied at the time of the incident in June 2016.

During interviews with RPN #113 and PSW #100 in September 2016, both stated that they were present and working on the morning of June 2106, and were the first to find resident #002 after the responsive behaviour incident. RPN #113 and PSW #100 verified that resident #002's bed device had not been applied.

During an interview with the DOC in September 2016, they stated that care set out in the plan of care should be provided to the resident as specified in the plan. The DOC verified the bed device had not been applied to resident #002's bed during the morning of June 2016.

The decision to issue this compliance order was based on the severity, which was determined to cause actual harm to resident #002. The scope was determined to be isolated; however, there was a history of previous noncompliance identified during the following inspections:

-A voluntary plan of correction (VPC) was issued in the Complaint Inspection #2016_264609_0009 served to the home on March 18, 2016;
-A voluntary plan of correction (VPC) was issued in the Resident Quality Inspection #2015_281542_0019 served to the home on October 5, 2015.
(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 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 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
Ontario, ON
M5S-2B1
Fax: 416-327-7603

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

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

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

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

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

Issued on this 19th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Moore

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