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

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
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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
Jun 19, 2017	2017_638609_0010	006745-17	Critical Incident System

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE PARRY SOUND ON P2A 2A2

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 12-13, 2017.

This inspection was conducted as a result of a Critical Incident (CI) report the home submitted, related to the transfer of resident #001 to the hospital with a significant change in their health status.

A Follow Up inspection #2017_638609_0009 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Food Services Manager (FSM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Cooks, Dietary staff, residents, the home's oxygen supply distributor and the West Parry Sound Health Centre records department.

The Inspector(s) also conducted a daily walk through of resident care areas, observed the provision of care towards residents, observed staff to resident interactions, reviewed residents' healthcare records, staffing schedules, staff training records, internal investigations, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **4 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. (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).

Findings/Faits saillants :

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.

A Critical Incident (CI) report was submitted to the Director, that outlined how resident #001 had an airway concern during a meal service on an identified day. The resident was then transferred to hospital and subsequently died.

A review of the hospital discharge summary indicated that resident #001 death was related to the airway concern.

A review of resident #001's most current plan of care indicated that the resident was to be provided with a specified texture diet.

A review of the resident #001's progress notes found that RN #105 indicated that the resident was expelling some debris prior to transfer to hospital and that it appeared to be remnants of a different textured diet than that specified in the resident's plan of care.

During an interview with RPN #107 they verified that they were present and working during the meal service on the the identified day, and indicated that they had looked at the plate that was served to resident #001 after the resident's airway concern. RPN #107 indicated that a portion of the meal resident #001 was eating prior to the incident appeared to be altered in a way that did not look like the specified texture.

During an interview with PSW #104 they verified that they were present and working with resident #001 during the meal service on the identified day. PSW #104 described that despite their concerns of the texture of the meal, they altered and served the meal to resident #001.

During an interview with the Food Services Manager (FSM) they verified that the specified texture of a portion of the meal served to resident #001 on the identified day's meal service would not have required any further alteration from the staff and would have come to the servery from the kitchen already altered.

During an interview with the DOC a review of the home's internal investigation was conducted. The investigation resulted in the staff members involved receiving corrective action.

A review of the home's policy titled "Resident Care Plan Protocol" effective date May 2010 indicated that the plan of care provided a guide for all staff providing care to the resident and that care set out in the care plan was provided to the resident as specified in the plan.

During an interview with the DOC they indicated that if a portion of the meal provided to resident #001 was correct during the identified day's meal service, it would not have required any further alteration by staff.

The DOC further indicated that if there was a disagreement between PSW staff and Dietary staff as to what texture a resident's diet was, they should have requested a registered staff member assess to ensure the proper texture was being provided prior to serving the meal and that PSW #104 did not do this. [s. 6. (7)]

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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, and any identified responsive behaviours.

A CI report was submitted to the Director which outlined how resident #001 had an airway concern during a meal service on an identified day.

A review of resident #001's progress notes for a 14 day period found five entries related to the resident's exhibited responsive behaviour at varying times during the day.

During an interview with PSW #102 they verified that they had previously provided care to resident #001 and indicated that the resident had a long standing exhibited responsive

behaviour.

During an interview with the RPN #107 they verified that they had previously provided care to resident #001 and indicated that the resident had a known exhibited responsive behaviour.

During an interview with the Registered Dietitian (RD) they verified that resident #001's responsive behaviour was previously identified as a long standing responsive behaviour.

None of the three staff members interviewed were able to identify triggers or interventions for resident #001's exhibited responsive behaviour.

A review of the home's policy titled "Responsive Behaviours/Gentle Care Approach" effective date March 2013 indicated that for a resident exhibiting responsive behaviours, the causes and triggers were to be identified in the plan of care.

A review of resident #001's health care records found that the home's physician assessed the resident's exhibited responsive behaviour as a chronic condition.

A review of resident #001's plan of care prior to their hospitalization found no mention of the responsive behaviour, causes, triggers or interventions.

During an interview with the DOC they verified that any identified responsive behaviours that were exhibited by a resident were to be documented in the resident's plan of care. The DOC verified that resident #001's plan of care should have identified the resident's exhibited responsive behaviour, its causes, triggers as well as interventions. [s. 26. (3) 5.]

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 responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, and any identified responsive behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

A CI report was submitted to the Director that outlined how resident #001 had an airway concern during a meal service on an identified day.

A review of resident #001's progress notes found that during the airway concern, RN #105 found that two of the home's specified machines required during the incident were not working.

During an interview with RN #105 they verified that they attempted to use two different unit's specified machines, but that they would not operate properly.

In an interview with the DOC on a particular day, the Inspector requested to see a specific unit's specified machine. The DOC and the Inspector observed the specified machine, with some supplies. When asked what the home's procedure was and who was responsible to ensure that the machine was in good repair and that all supplies were available, the DOC stated that there was currently no procedure in place.

A review of the home's policy titled "Preventative Maintenance Schedule" effective date October 2015 indicated that the home would establish and implement a preventative maintenance system.

During another interview with the DOC they indicated that the home had signed a new contract with a company to provide new specified machines to the home.

During an interview with the Distributor for the new specified machines they indicated that regardless of type of specified machine, it was the responsibility of the home to implement a process to ensure that the specified machines were operational and that all supplies were available. The Distributor indicated that this would typically occur every one to two months. [s. 90. (2) (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 procedures are developed and implemented to ensure that, all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an injury to a resident of which they were taken to hospital with a significant change in the resident's health condition.

A CI report was submitted to the Director on an identified day at a particular time. The CI report outlined how resident #001 had an airway concern during a meal service on an identified day during a particular time. The resident was transferred to the hospital. At a particular time the home was informed that the resident was admitted.

A review of the home's policy titled "Critical Incident Reporting" effective November 2012 indicated that the Director was to be informed within one business day of an injury which a resident was taken to hospital.

During an interview with the DOC they verified that they became aware of resident #001's transfer to hospital on a particular day, after reviewing progress notes. The DOC further verified that despite being aware of the incident, the CI report submission was delayed one day to the Director. [s. 107. (3) 4.]

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 Director is informed no later than one business day after the occurrence of an injury to a resident of which they are taken to hospital with a significant change in the resident's health condition, to be implemented voluntarily.

Issued on this 6th day of July, 2017

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) :	CHAD CAMPS (609)
Inspection No. / No de l'inspection :	2017_638609_0010
Log No. / Registre no:	006745-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2017
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	BELVEDERE HEIGHTS 21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marsha Rivers

To BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

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:

a) Ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

b) Specifically ensure that no resident is provided a meal not consistent with their assessed diet texture and plan of care.

c) Develop and implement a process to ensure that when staff have a disagreement about, including but not limited to, what diet texture a resident is to be provided, that the disagreement is clarified before food and fluids are provided to the resident.

d) Provide comprehensive retraining to all staff involved in meal services to residents to ensure all are aware of diet textures and what do to if a diet texture (or any other aspect of the meal service) is in question.

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.

A Critical Incident (CI) report was submitted to the Director, that outlined how resident #001 had an airway concern during a meal service on an identified day. The resident was then transferred to hospital and subsequently died.

A review of the hospital discharge summary indicated that resident #001 death was related to the airway concern.

A review of resident #001's most current plan of care indicated that the resident was to be provided with a specified texture diet.

A review of the resident #001's progress notes found that RN #105 indicated that the resident was expelling some debris prior to transfer to hospital and that it appeared to be remnants of a different textured diet than that specified in the resident's plan of care.

During an interview with RPN #107 they verified that they were present and working during the meal service on the the identified day, and indicated that they had looked at the plate that was served to resident #001 after the resident's airway concern. RPN #107 indicated that a portion of the meal resident #001 was eating prior to the incident appeared to be altered in a way that did not look like the specified texture.

During an interview with PSW #104 they verified that they were present and working with resident #001 during the meal service on the identified day. PSW #104 described that despite their concerns of the texture of the meal, they altered and served the meal to resident #001.

During an interview with the Food Services Manager (FSM) they verified that the specified texture of a portion of the meal served to resident #001 on the identified day's meal service would not have required any further alteration from the staff and would have come to the servery from the kitchen already altered.

During an interview with the DOC a review of the home's internal investigation was conducted. The investigation resulted in the staff members involved receiving corrective action.

A review of the home's policy titled "Resident Care Plan Protocol" effective date May 2010 indicated that the plan of care provided a guide for all staff providing care to the resident and that care set out in the care plan was provided to the resident as specified in the plan.

During an interview with the DOC they indicated that if a portion of the meal provided to resident #001 was correct during the identified day's meal service, it would not have required any further alteration by staff.

The DOC further indicated that if there was a disagreement between PSW staff and Dietary staff as to what texture a resident's diet was, they should have requested a registered staff member assess to ensure the proper texture was being provided prior to serving the meal and that PSW #104 did not do this.

The scope of this issue was determined to have been isolated to the one incident on March 25, 2017. There was a previous Voluntary Plan of Correction (VPC) issued related to this provision during inspection #2015_376594_0017 on October 15, 2015. The severity was determined to have been actual harm to the health, safety and well-being of resident #001 who aspirated after being provided an incorrect textured meal and subsequently dying five days later. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 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 June, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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