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
Jun 6, 10, Jul 4, Oct 24, 2016	2016_333577_0012	011642-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

BETHAMMI NURSING HOME
63 CARRIE STREET THUNDER BAY ON P7A 4J2

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

DEBBIE WARPULA (577), JENNIFER KOSS (616), JULIE KUORIKOSKI (621)

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): May 24, 25, 26, 27, 30, 31 and June 1, 2 and 3, 2016

Additional logs inspected during this RQI include:

A Follow up log for three previous Compliance Orders, issued on November 27, 2015, with a compliance date of December 4, 2015;

Two Complaint logs related to staffing concerns and resident care; and

Three Critical Incident logs, one related to resident to resident abuse, one related to a resident fall and one related to staff to resident abuse.

The inspector(s) conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed resident health care records, and reviewed many of the homes policies, procedures and programs.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Food Services Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Staff Educator, Unit Clerk, Dietary Aides, Manager of Motion Specialties, Physiotherapist, Resident Assessment Instrument (RAI) Coordinator, Personal Support Workers (PSW), residents and family members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **13 VPC(s)**
- **7 CO(s)**
- **2 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. 110. (2)	CO #903	2016_333577_0012	577
O.Reg 79/10 s. 15. (1)	CO #904	2016_333577_0012	577
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #002	2015_333577_0016	621

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. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident.

During observations on a day in May 2016, Inspector #616 observed resident #005's bed with one upper and lower bed rail in the guard position.

During a record review of the resident's care plan, Inspector #577 noted a nursing intervention indicated to ensure four bed rails were in the guard position when the resident was in bed.

During an interview with PSW #101 they reported that the resident used four bed rails.

During observations on a day in May 2016, Inspector #577 observed resident #003 in bed with upper and lower bed rails in the guard position.

During a record review of the resident's care plan, Inspector #577 noted a nursing intervention that indicated two bed rails in guard position.

During an interview with PSW #100, they reported that the resident used two bed rails.

During observations on two days in May 2016, Inspector #577 observed resident #002 in their bed with one half bed rail in the guard position.

During a record review of the resident's care plan, the Inspector noted a nursing intervention that indicated top bed rail in guard position when resident was in bed.

During an interview with RPN #103 they reported that the resident used a top bed rail. They further reported that they were unsure who was responsible for assessing residents for bed rails.

Inspector #577 conducted an interview with the DOC who reported that the home did not perform bed rail assessments and registered staff determined on admission whether bed rails were needed. The Occupational Therapist (OT) and Physiotherapist (PT) would also make recommendations. The DOC also confirmed that the bed rail assessment tool kit was currently in draft and staff were following the restraint policy. [s. 15. (1) (a)]

2. During an interview with the DOC, they reported to Inspector #577 that a bed safety audit with recommendations was conducted in 2012.

During a record review of the audit,the Inspector found that between April and May 2012, Shoppers Home Health inventoried 108 beds within the home, which included an inventory of bed frames, mattresses and a full entrapment audit. The audit did not identify bed locations within the home and identified that the following bed systems had failed, as follows:

-Stryker FL-14E1: 12 beds failed in zones 2, 3, 4, 5, 6, 7 and mattress/top of rail height;

-Stryker FL-14E3: 12 beds failed in zones 2, 3, 4, 5, 6, 7 and mattress/top of rail height;

-Bertec FL-13E78: 74 beds failed in zones 2, 3, 4 and mattress/top of rail height; and

-Joerns U770: 6 beds failed in zone 7 and mattress/top of rail height.

During an interview with the DOC they confirmed that according to the audit, 104 beds had failed in 2012 and they were unable to provide any records to confirm that recommendations were made and was not completed as recommended. [s. 15. (1) (a)]

3. As part of an immediate order that was issued June 10, 2016, the home was instructed to conduct an audit identifying the location and type of bed rails used.

On a day in June 2016, Inspector #577 reviewed the home's audit, titled "Bed Rail Safety Analysis" and "Bed Safety Analysis" and found 52/106 or 49 percent did not indicate the location and type of bed rails used.

During an interview with the Administrator they confirmed that the audit did not include the location and type of bed rails used for 49 percent of those residents. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 901, 904 were 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. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
4. Consent. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirements were met when a resident was being restrained by a physical device under section 31 of the Act: 2: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

A review of the health care records for resident #005 by Inspector #577 identified a physician's order for a rear closing apparatus dated March 2016.

During observations of resident #005, Inspector #577 found incorrect application of the

resident's rear closing apparatus, as follows:

On a day in May 2016- resident #005 was seated in their special chair with an apparatus in place and it was loose. The Inspector confirmed the incorrect placement of the apparatus with RPN #127 and they readjusted and tightened the apparatus;

On another day in May 2016, at 1313 hrs and 1607 hrs- resident #005 was seated in their special chair with an apparatus secured around the inside frame and it was loose. Inspector confirmed incorrect placement of the apparatus with PSW #116 and they secured the apparatus to the outside frame of special chair;

On another day in May 2016, at 0926 hrs and 1525 hrs- resident #005 was seated in their special chair with an apparatus secured around the inside of the special chair and it was loose. The Inspector confirmed the incorrect placement of the apparatus with the DOC and they secured the placement of the apparatus underneath the frame of the special chair on the right side;

On another day in June 2016- resident #005 was seated in their special chair with an apparatus secured to the inside of chair and it was loose. The Inspector confirmed the incorrect placement of the apparatus with PSW #116 and they adjusted the apparatus; and

On another day in June 2016- resident #005 was seated in their special chair with an apparatus secured to the inside of the chair and it was loose. Inspector confirmed incorrect placement with the DOC and they secured the apparatus around the resident and underneath the frame of the special chair on the right side.

During an interview with PSW #100 on a day in May 2016, when the resident's apparatus was loose, they reported that they were not sure if the apparatus was applied correctly and told the Inspector to speak with the registered staff. They further reported they have had training on the apparatus but was not sure about proper application. During an interview with RPN #121 and RN #120 they reported that the loose fitting apparatus was applied correctly.

During an interview with the Educator #124 they reported that staff were trained with the least restraint toolkit, annual medworx, requirements for use, but were not shown application of restraints. They reported that they have not seen any manufacturer's instructions for restraint application for staff.

During an interview with the Manager of Motion Specialties #122, they reported that the standard restraint belts did not contain any information about manufacturer's instructions and arrived in a ziplock style packaging. They further reported that the rear facing seatbelts were bolted to one side of the wheelchair and the belt was secured around the resident at a 45 degree angle behind the back of the wheelchair.

During a record review of the homes policy titled "Least Restraint Program" - LTC 3-100, last revised May 2013, it indicated:

-registered staff will obtain a physician's order or Nurse Practitioner's order for the type and reason for restraint
-registered staff supervises the application of the restraint according to the order and manufacturer's instructions

During an interview with the DOC, they reported that there were no manufacturing instructions for restraints. They further reported that staff were trained on the least restraints toolkit, annual medworx, requirements for use, but were not shown the application of restraints. They confirmed that it was the expectation of the home that staff apply rear facing seatbelts correctly and securely and resident #005 had incorrect placement on multiple occasions. [s. 110. (2) 1.]

2. During observations of resident #030 on a day in June 2016, Inspector #577 found incorrect application of the resident's front facing apparatus. The Inspector was able to place two closed fists between the resident and the apparatus. PSW #125 confirmed improper placement with the Inspector, and staff tightened the apparatus.

During a record review Inspector could not find a physician's order for the apparatus.

During an interview with RPN #126 and the DOC, they both confirmed that resident #030 did not have an order for an apparatus and the DOC removed the apparatus.

During an interview with the Administrator they confirmed that it was the expectation of the home that residents had properly placed restraints with orders from a physician or registered nurse in the extended class. [s. 110. (2) 1.]

3. During observations of resident #031, Inspector #577 found incorrect application of resident's apparatus, as follows:

On a day in June 2016- resident #031 seated in a special chair with a loose fitting apparatus. The Inspector placed a closed fist between the resident and their apparatus. RN #107 confirmed with the Inspector that the apparatus was applied incorrectly and did not have a physician's order.

On another day in June 2016- resident #031 seated in a special chair with a loose fitting apparatus. The Inspector placed a closed fist between the resident and their apparatus. The DOC confirmed incorrect placement with the Inspector and reported that they were waiting for OT to tighten the apparatus.

During an interview with PT #123, they confirmed that the resident's apparatus was loose and OT assessed and fixed the apparatus.

During an interview with the DOC on a day in June 2016, they confirmed that resident #031 did not have an order for an apparatus from a physician or registered nurse in the extended class. They further confirmed that it was the expectation of the home that staff obtained orders for apparatus and were applied correctly. [s. 110. (2) 1.]

4. The licensee failed to ensure that the following requirements were met where a resident was being restrained by a physical device under section 31 of the Act: That staff only applied the physical device that had been ordered or approved by a physician or registered nurse in the extended class

During observations of resident #030, Inspector #577 found a loose front facing apparatus on. Inspector confirmed with the resident that they could not unfasten their apparatus. The Inspector confirmed the placement of the apparatus with PSW #125.

During a record review the Inspector could not find a physician's order for the apparatus.

During a record review of the home's policy titled "Least Restraint Program" - LTC 3-100, last revised May 2013, indicated that registered staff were to obtain a physician's order or Nurse Practitioner's order for the type and reason for restraint as well as duration of the restraint.

During an interview with RPN #126 and the DOC, they both confirmed that resident did not have an order for an apparatus and the DOC removed the application.

During an interview with the Administrator they confirmed that it was the expectation of the home that residents had properly placed apparatus with orders that were approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

5. During observations of resident #031 on a day in June 2016, Inspector #577 found a loose apparatus on. The Inspector confirmed with the resident that they could not unfasten the apparatus. The Inspector confirmed placement of the apparatus with RN #107.

During a record review Inspector could not find a physician's order for the apparatus.

During an interview with RN #107 and the DOC, they both confirmed that the resident did not have an order for an apparatus.

During an interview with the Administrator they confirmed that it was the expectation of the home that residents had properly placed apparatus with orders that were approved by a physician or registered nurse in the extended class. [s. 110. (2) 1.]

6. During observations of resident #005 on a day in June 2016, Inspector #577 found incorrect application of the resident's apparatus. The resident was seated in their special chair with a loose fitting apparatus. The Inspector placed a closed fist between the resident and the apparatus. The Inspector confirmed incorrect placement of the apparatus with the Administrator and they tightened the apparatus.

During observations of resident #039 on a day in June 2016, Inspector #577 found incorrect application of the resident's apparatus. The resident was seated in their special chair with a loose fitting apparatus. Inspector confirmed incorrect placement of the apparatus with the Administrator and they tightened the apparatus.

During an interview with the Administrator they confirmed that the home provided training to staff regarding apparatus use. They further confirmed that it was the expectation of the home that staff applied apparatus correctly and securely and resident #005 and #039 had incorrect placement of their apparatus. [s. 110. (2) 2.]

7. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: Consent.

During observations on a day in May 2016, Inspector #616 noted an apparatus on resident #005.

A review of the health care records conducted by Inspector #577, identified a physician's order for the apparatus dated March 2016. The Inspector further found a consent from the Substitute Decision Maker (SDM) for the use of bed rails and a different type of apparatus. The consent did not include the type of apparatus that was observed on the resident.

During a record review of the homes policy titled "Least Restraint Program" - LTC 3-100, last revised May 2013, it indicated that staff would ensure that the resident/SDM has provided informed consent for the use of the apparatus.

During an interview with RN #120 they confirmed that an SDM consent was not obtained for resident's apparatus and consent should be always obtained from the SDM.

During an interview with the DOC, they confirmed that it was the expectation of the home that staff obtained SDM consent for the apparatus, and staff had not obtained consent for the type of apparatus used by resident #005. [s. 110. (7) 4.]

8. During observations of resident #030 on a day in June 2016, Inspector #577 found a loose apparatus placed around resident's waist. The Inspector confirmed with the resident that they could not unfasten the apparatus. The Inspector confirmed placement of the apparatus with PSW #125.

During a record review of the resident's health care records, the Inspector could not find a consent from the Substitute Decision Maker (SDM) for the apparatus.

During an interview with RPN #126 and the DOC, they both confirmed that the resident did not have a SDM consent for an apparatus and the DOC removed the application.

During an interview with the Administrator they confirmed that it was the expectation of the home that residents had SDM consent for the apparatus. [s. 110. (7) 4.]

9. During observations of resident #031 on a day in June 2016, Inspector #577 found a loose fitting apparatus placed around the resident. Inspector confirmed with the resident that they could not unfasten the apparatus. The Inspector confirmed placement of the apparatus with RN #107.

During a record review of the resident's health care records, the Inspector could not find a consent from the Substitute Decision Maker (SDM) for a front facing apparatus.

During an interview with RN #107 and the DOC, they both confirmed that resident did not have a SDM consent for an apparatus.

During an interview with the Administrator they confirmed that it was the expectation of the home that residents have SDM consent for the apparatus. [s. 110. (7) 4.]

10. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: 7. Every release of the device and all repositioning.

Inspector #577 conducted a record review of resident #005's electronic apparatus monitoring record concerning the apparatus for the month of May 2016. The Inspector found many inconsistencies in the documentation for their apparatus. Inconsistencies indicated as follows:

-registered staff documentation indicated that on 29/31 days, the resident had their apparatus on, and

-PSW monitoring of the rear facing apparatus indicated that 23/31 days had no documentation at all and 5/31 days had incomplete documentation.

During a review of the home's policy titled "Least Restraint Program" - LTC 3-100, last revised May 2013, it indicated the following:

-registered staff supervised the application of the apparatus;

-registered staff directed the PSW to monitor the resident hourly and to release and reposition the resident every two hours;

-PSW's reposition the resident at least every two hours as directed by registered staff, and

-PSW's checked the resident hourly and documented on the apparatus monitoring form.

During an interview with the DOC, they confirmed that the apparatus documentation completed by the PSW's was inconsistent and that the deficient documentation confirmed that staff were not releasing and repositioning every two hours and not documenting it. [s. 110. (7) 7.]

Additional Required Actions:

CO # - 902, 903 were served on the licensee. Refer to the "Order(s) of the Inspector".
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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: Consent, specifically in regards to resident #005, #030, #031 and all other residents; and to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: Every release of the device and all repositioning, specifically in regards to resident #005 and all other residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

As part of this Resident Quality Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection #2015_333577_0016. The

licensee was ordered to be in compliance with the following order by December 4, 2015:

"The licensee shall ensure that resident #015 and all other residents are protected from abuse by anyone and shall ensure that all residents are not neglected by staff".

O. Reg. 79/10 defines 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.

A Critical Incident (CI) report was submitted to the Director in February 2016, related to an incident that occurred four days prior. The report identified that resident #026 had abused resident #027 in their bedroom. PSW #130 had reported to RN #131 that they had witnessed resident #027 in bed, with resident #026 also on the bed engaged in an encounter. As per the CI report, resident #027 did not appear to be aware of what had happened.

Inspector #616 reviewed resident #026's health record related to inappropriate responsive behaviours history. Documentation was found within the admission information of the record from 2013 to 2015, that indicated multiple references of this resident's known inappropriate responsive behaviour history toward co-residents and co-patients.

The Inspector reviewed resident #026's the care plan in effect at the time of the incident, dated November 2015. There was no focus, goals, or interventions identified for this resident's known history of inappropriate responsive behaviours. The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

During an interview with the DOC on a day in June 2016, they stated it was an expectation that staff should have been made aware of the potential risk of inappropriate responsive behaviours from resident #026 to other residents and interventions should have been identified in the resident #026's care plan but had not been.They further reported that staff had no knowledge of resident #026's history of inappropriate responsive behaviour as per the previous health record, and interventions should have been identified in the resident's plan of care but had not been.

Additionally, the home failed to protect residents in the home from abuse by resident #026 as evidenced by non-compliance identified during this inspection related to:

WN #4, LTCHA, 2007 S.O. 2007, c. 8, s. 24 (1) where the home failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director;
WN #9, LTCHA, 2007 S.O. 2007,c. 8, s. 20 (1) where the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with; and
WN #12, LTCHA, 2007, O. Reg. 79/20, s. 54 where the licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation that could potentially trigger such altercations. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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, 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 a person who had reasonable grounds to suspect that 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, immediately reported their suspicion and the information upon which it was based to the Director.

As part of this Resident Quality Inspection, the inspectors were following up on outstanding compliance order #003 issued during inspection #2015_333577_0016. The licensee was ordered to be in compliance with the following order by December 4, 2015:

"The licensee shall ensure that a person who has reasonable grounds to suspect that 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 is to immediately report the suspicion and the information upon which it is based to the Director".

A Critical Incident (CI) report was submitted to the Director in February 2016, related to an incident that occurred in February 2016. The report identified that resident #026 had abused resident #027 in their bedroom. PSW #130 had reported to RN #131 that they had witnessed resident #027 in bed, with resident #026 also on the bed engaged in an encounter. As per the CI report, resident #027 did not appear to be aware of what had happened.

Inspector #616 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents, Reporting and Notifications about Incidents of Abuse or Neglect" - #LTC 5-51, revised February 2016. This policy stated that upon immediate notification of an incident, the Director/designate would notify the Ministry by phone and included contact information for notification during evenings and weekends. It further stated that notification was followed by immediate initiation of the (Ministry) report using the on line Mandatory Critical Incident System form.

During an interview with the DOC on a day in June 2016, they stated they had been notified of the incident within the hour after it occurred but was confused between the reporting timelines of Mandatory Reporting and Critical Incident reporting, and therefore they had not notified the Ministry until four days after the incident occurred. [s. 24. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a weight monitoring system in place to measure and record each resident's weight on admission and monthly thereafter.

A review of the home's electronic health record by Inspector #621 found multiple residents did not have documented weights for one or more months from January 2016, to May 2016.

It was determined that during this time period monthly weights were not documented in the electronic health record for the following residents:

-Resident #010 - no weight documented for February 2016
-Resident #012 – no weight documented for January and February 2016
-Resident #013 – no weight documented for February 2016
-Resident #014 – no weight documented for February, March and April 2016
-Resident #015 – no weight documented for January and February 2016
-Resident #016 – no weight documented for January and February 2016
-Resident #017 – no weight documented for February 2016
-Resident #002 – no weight documented for February 2016
-Resident #032- no weight completed in February or March 2016
-Resident #033- no weight completed in February 2016
-Resident #034- no weight completed in February 2016
-Resident #035- no weight completed in February or March 2016
-Resident #036- no weight completed in February or April 2016

A review of the home's policy entitled "Unintentional Weight Loss or Gain" - LTC 5-10, last revised January 2013, identified that residents were weighed on the same scale, at the same time of day each month usually on bath day; and weights are recorded in the electronic record and regularly reviewed by the dietitian.

During an interview on a day in May 2016, PSW #105 identified to Inspector #621 that weights on all residents were obtained on bath days by the 15th of each month and a paper record was kept in the tub room on each unit.

During an interview with RPN #103 they reported that resident weights obtained by PSW staff each month on bath days were entered into the electronic health record by the night shift PSW by the 15th of each month.

During a review of the weight records on the electronic health record, it was identified by RPN #103 that a combined total of 13 monthly weights were missing between January 2016 and May 2016, for resident's #010, #012, #013, #014, #015, #016, #017, and #002.

During an interview with the DOC on a day in May 2016, they identified to Inspector #621 that it was their expectation that residents had a monthly weight taken and documented in the electronic health record by the night PSW no later than the 15th of the month. The DOC reviewed the weight records for resident #010, #012, #013, #014, #015, #016, #017

and #002 and confirmed that not all monthly weights were recorded in the electronic health record. [s. 68. (2) (e) (i)]

2. The licensee has failed to ensure that there was a weight monitoring system to measure and record with respect to each resident's body mass index and height upon admission and annually thereafter.

During resident census record reviews, Inspector #616 identified that four residents of 13, or 31 per cent of the sample, did not have an annual height measured. One resident's height was last measured in 2012, two were measured in 2013, and one in 2014.

The home's policy titled "Resident Weight/Height" - DS C-05-115, last revised May 28, 2015, indicated the standard: that each resident's height shall be recorded on admission and yearly thereafter. The policy further stated that the Ideal Body Weight or Average Weight for Height for Age will change as the resident moves to the next age bracket. This will be monitored annually by the Registered Dietitian (RD) or Food Service Supervisor (FSS) while completing quarterly assessments.

RPN #103, stated to Inspector #616 that staff measure the resident's height on admission, and annually, timed with the Resident Assessment Instrument-Minimum Data Set (RAI-MDS). They explained that the PSW's obtained the height measurement and entered the data directly into the resident's electronic record.

During an interview with RPN #102, they identified that the last height measurements for the four identified residents were not obtained annually and should have been. [s. 68. (2) (e) (ii)]

Additional Required Actions:

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

WN #6: 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. (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.

Observations of resident #003 were made by Inspector #616 on three days in May 2016, and one day in June 2016, related to personal grooming. On these dates, facial hair was noted on the resident's upper lip and chin areas.

Observations of resident #009 were made by the Inspector on three days in May 2016, and one day in June 2016, related to personal grooming. On three of the four dates, the resident's facial hair had not been shaved.

During an interview with each resident, they both stated to the Inspector that they preferred to have their facial hair removed daily and required the assistance from staff to complete this task.

During an interview with RPN #135, they stated that the general practice by staff was to provide personal grooming of the residents' facial hair on their specific bath days. However, they added that if the resident preferred specific care, such as a daily shave, that information would be indicated on the individual care plans.

A review of resident #003's current personal hygiene care plan dated May 2016, indicated that the resident required assistance to maintain abilities to maintain grooming.

A review of resident #009's current personal hygiene care plan dated May 2016, indicated that the resident required assistance of staff for personal care.

Neither care plan provided reference to facial hair removal, nor their preferences for a daily shave.

During an interview with PSW #136, they stated that resident #003 would have been asked by staff each morning during care if they wanted their facial hair removed. Regarding resident #009, they stated this resident, did like a daily shave. They stated their care plan would give direction to staff about how often they were to be shaved.

PSW #136 reported that staff documented this care activity in the resident's electronic record. In addition, they stated that the planned care for personal grooming-shaving would be located within the resident's current care plan, filed in their charts.

During the Inspector's interview with PSW #116, they stated that resident #003 did not receive assistance with facial hair removal by staff, nor would they complete this task independently as they did not prefer to have their facial hair removed. Regarding facial hair grooming for resident #009, they stated they were aware that this resident preferred a daily facial shave and the care would be in their care plan.

The Inspector reviewed each resident's task report for the "shaving" activity completed by PSW staff for the month of May 2016. For resident #003, this activity was documented as completed three times throughout the month. Resident #009's shaving task was documented as completed eight times throughout the month.

During an interview with the RAI Coordinator #109, they stated that the current care plans for both resident #003 and resident #009 did not identify the planned care and preference for daily facial hair removal. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

A Critical Incident (CI) report was submitted to the Director by the home in October 2015,

related to resident #025's fall in October 2015, which resulted in an injury. The report indicated that the resident was known to self-transfer independently. In addition, the report identified that the resident had two previous falls in October 2015.

Inspector #616 reviewed the resident's care plan in effect at the time of the CI which was dated June 2015. The Falls/Balance focus of the care plan indicated that the resident had a fall in September 2015, and was identified to be at risk for falls. The care planned interventions included fall prevention strategies.

The Inspector reviewed the bowel, toileting, and transferring focus of the care plan in effect prior to their fall on October 25, 2015. The care planned interventions included toileting and transferring interventions. The care plans were not updated after any of the falls that would indicate that the resident had a history of self-transferring.

The Inspector reviewed the resident's progress notes related to their recent falls history from September to October 2015. The resident had four falls documented and suffered injuries from two of the falls.

A review of the most recent post-fall assessment was completed in September 2015, which indicated that the resident was at risk for falls.

During an interview with the DOC, they stated to the Inspector that the care plan in effect at the time of the October 2015, fall dated June 2015, and resident #025's four falls from September to October, the care planned interventions were not effective in falls prevention in meeting the care planned goal of no falls with injury and the care plan should have been revised. [s. 6. (10) (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 there is a written plan of care for each resident that sets out the planned care for the resident, specifically in regards to resident #003 and #009; and to ensure that resident's are reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective, specifically in regards to resident #025, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

s. 8. (4) During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations. 2007, c. 8, s. 8 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During a record review of the RN shift schedule from November 2015 to February 2016, Inspector #577 found multiple shifts where the home did not have a Registered Nurse on duty in the home. The following dates were identified:

-two evening shifts in November 2015

-an evening shift in December 2015
-five evening shifts in December 2015
-two day shifts in January 2016
-two evening shifts in February 2016
-a night shift in February 2016

During a review of the home's document titled "Bethammi Nursing Home Shift Replacement Guidelines", it indicated the following guidelines to follow for RN shortages:

-day and evening shift: call RN at straight time and overtime, if unable to replace, call in an extra RPN
-night shift: call RN at straight time and overtime, if unable to replace, call in an extra RPN; ask RN to be on-call

During an interview with the DOC, they reported that one RN was always scheduled but in the event that they could not be replaced, an RPN would be scheduled and an RN was on call. They further confirmed that the home was without an RN in the home during the shifts identified. [s. 8. (3)]

2. The licensee failed to ensure that an Administrator or Director of Nursing and Personal Care who worked in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations.

During a record review of the homes RN shift schedule from November 2015 to February 2016, Inspector #577 found documentation that on a day in December 2015, the home was without an RN and the DOC worked as the RN on that day.

During an interview with the DOC, they confirmed that on a day in December 2015, they were on duty as the DOC and also acted in the capacity of the RN. [s. 8. (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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations; and to ensure that an Administrator or Director of Nursing and Personal Care who works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

On a day in May 2016, Inspector #616 observed one of the nursing units floor balcony door to the patio wide open. A sign posted on the door read: "Door to be locked at all times when not in use. Residents must be accompanied by or closely supervised by staff, family, or a volunteer while on the balcony. The RN or RPN on duty will open the door at your request and must be notified when leaving the balcony so they may re-lock the door".

No residents were observed on the balcony patio area at this time. The Inspector noted that the perimeter of the balcony was enclosed with a metal railing approximately 36 inches high mounted to a cement border of approximately 12 inches high from the floor of the patio. A portion of the patio was covered with a wooden pergola at the balcony door, however the space above the railing around the perimeter of the patio was not enclosed. There were numerous patio chairs observed on the balcony which could be moved.

The Inspector proceeded down the corridor toward the nursing station while maintaining view of the balcony door. A number of staff were observed in the team room beside the nursing station at this time and no staff came toward the balcony door.

Together with the Inspector, the DOC observed the open balcony door. The DOC stated that this door should have been locked at all times when not in use.

On another day in May 2016, Inspector #621 observed the same nursing unit floor balcony door to the patio being opened by resident #029, unsupervised, and this resident entering the patio briefly before exiting back onto the unit. Inspector #621 observed no unit staff in proximity to the balcony door at this time.

Inspector #621 interviewed Clerk #104 who confirmed that the patio door at the south end of the floor was unlocked and unattended. They also verified that the sign on the patio door indicated that the door was to be locked at all times. [s. 9. (1) 1.1.]

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 all doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #9: 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. (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 home's written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident (CI) report was submitted to the Director by the home on a day in February 2016, related to an incident that occurred four days prior. The report identified that resident #026 had abused resident #027 in their bedroom. PSW #130 had reported to RN #131 that they had witnessed resident #027 in bed, with resident #026 also on the bed, in an encounter. Resident #027 did not appear to be aware of what had happened.

The home's investigation record and this inspection determined that the home failed to protect resident #027 from abuse as per policy.

The home’s policy titled "Zero Tolerance of Abuse and Neglect of Residents", #LTC-5-50, last revised February 2016, stated that residents living in the home have “the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s dignity and individuality and to be from mental and physical abuse”. The policy referenced the Long-Term Care Homes Act, where sexual abuse means any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than an employee.

The Inspector reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents, Reporting and Notifications about Incidents of Abuse or Neglect, #LTC 5-51", last revised February 2016. This policy stated that upon immediate notification of an incident, the Director/designate would notify the Ministry by phone and included contact information for notification during evenings and weekends. It further stated that notification was followed by immediate initiation of the (Ministry) report using the on line Mandatory Critical Incident System form.

The home's investigation record and this inspection which included an interview with the DOC where they stated they had been notified of the incident shortly after it occurred and had been confused between the reporting timelines of Mandatory Reporting and Critical Incident reporting, and therefore had notified the Ministry four days later, not immediately as per policy. [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 written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #10: 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. The licensee has failed to ensure that any written complaints received concerning the care of a resident or the operation of the home, were forwarded immediately to the Director.

Inspector #621 reviewed a copy of the homes policy titled "Complaints Management Program" - LTC 5-70, last revised February 2016, which identified that it was the responsibility of the Manager to report to the Ministry of Health and Long-Term Care (MOHLTC) all written complaints received.

During the inspection, resident #002's Substitute Decision Maker (SDM) reported to Inspector #621 that they had forwarded written complaints in May and September 2015, to the home's Administrator and DOC regarding a number of resident care concerns at that time. The SDM identified a concern that these complaints had not been reported by the home to the MOHLTC as required.

The SDM provided Inspector #621 with copies of email correspondence between the SDM and the home which identified an email dated May 2015 and a letter dated September 2015, with the following concerns:
-absence of a Registered Nurse on duty for two shifts in April 2015
-soiled clothing and bedding found in this resident's room in April 2015
- bathing of the resident occurring less than twice weekly, and staff not ensuring the resident was groomed and dressed appropriately.

It was identified in the correspondence provided by the SDM that these written concerns were acknowledged by the home within one business day. Follow-up correspondence to review and address these concerns was arranged with the SDM in May and September 2015, respectively.

During an interview with current DOC #111 on a day in May 2016, it was reported to Inspector #621 that previous DOC #124 was involved in the follow up on complaints submitted to the home prior to mid September 2015. It was confirmed by DOC #111 that the home did not immediately forward the written complaints regarding resident #002 from May 2015, and September 2015, to the Director. [s. 22. (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 any written complaints received concerning the care of a resident or the operation of the home, is forwarded immediately to the Director, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A Critical Incident (CI) report was submitted to the Director by the home in October 2015, related to resident #025's fall in October 2015, which resulted in an injury. In addition, the report identified the resident had two other falls in October 2015.

Inspector #616 reviewed the resident's care plan in effect at the time of the fall with injury was dated June 2015. The Falls/Balance focus of the care plan indicated that the resident had a fall in September 2015, and was identified to be a risk for falls.

The Inspector reviewed the resident's progress notes related to their recent falls history from September to the fall with injury in October 2015. The resident had four falls documented from September to October 2015.

A review of the home's policy titled "Falls Prevention and Management Program" - LTC 3 -60, last revised April 2014, stated the registered staff would lead the team to complete the Post Fall Assessment following each resident fall.

During interviews with the RAI Coordinator #109, RPN #113, and RPN #114, they stated to the Inspector that the registered staff documented post-fall assessments on the resident's electronic health record, following each fall incident.

A review of the resident's assessments in their electronic health record identified a post-fall assessment dated in September 2015, and no post-fall assessments for the falls in October 2015.

During an interview with the DOC, they stated that registered staff documented a resident's fall in the resident's progress notes, as well as completed a post-fall assessment in the resident's electronic health record. The DOC stated staff should have completed the post-fall assessment in September 2015, following the incident, not nine days after the fall. They also stated there should have been a post-fall assessment completed following resident #025's three falls in October 2015. [s. 49. (2)]

2. During a records review, Inspector #621 identified that there was no post fall assessment available from the electronic health record for an unwitnessed fall involving resident #006 in January 2016, and for resident #007 in May 2016.

On a day in May 2016, a records review with the RAI Coordinator #109 confirmed that a Post Fall Assessment was not completed for resident #006’s fall in January 2016, or for resident #007’s fall in May 2016. [s. 49. (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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation that could potentially trigger such altercations.

A Critical Incident (CI) report was submitted to the Director in February 2016, related to an incident that occurred four days prior. The report identified that resident #026 had abused resident #027 in their bedroom. PSW #130 had reported to RN #131 that they had witnessed resident #027 in bed, with resident #026 also on the bed, engaged in an encounter. Resident #027's did not appear to be aware of what had happened.

Inspector #616 reviewed the resident #026's health record related to inappropriate responsive behaviours history. Documentation was found within the admission information of the record from 2013 to 2015, with multiple references that identified this resident's known inappropriate responsive behaviour history toward co-residents and co-patients.

The inspector reviewed the care plan in effect at the time of the incident with co-resident #027 dated November 2015. There was no focus, goals, or interventions identified for resident #026's known history of inappropriate responsive behaviours.

During an interview with the DOC on a day in June 2016, they stated it was an expectation that staff should have been made aware of potential risks of inappropriate responsive behaviour on the resident's admission to the home. They stated staff had no knowledge of this history as per the previous health record, and interventions should have been identified in the resident's plan of care but had not been. [s. 54. (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

During an observation of the afternoon snack service for a home area on a day in May 2016, it was identified that the planned snack menu listed residents on regular, diabetic, soft/minced and pureed diets were to be provided a scoop of ice cream for the afternoon nourishment pass. Inspector #621 reviewed the servery area on the home area at 1430 hrs and found sandwich quarters, as well as pureed and diced peaches left in the servery refrigerator, but no ice cream. At 1600 hrs the Inspector observed Dietary Aide #118 remove the sandwiches and peaches from the servery refrigerator and proceeded to take them back to the main kitchen.

During an interview with Dietary Aide #118, they reported to Inspector #621 that the afternoon snack provided on that day in May 2016, was peanut butter and jam sandwich quarters, diced and pureed peaches. They identified that they were removing these items to return to the main kitchen as afternoon snack service was completed.

Upon review of the planned snack menu, Dietary Aide #118 reported to Inspector #621

that residents should have received ice cream as the afternoon snack choice. However, they identified that what often happened was the cook prepared snacks for the dietary staff that did not match the planned menu.

On a day in June 2016, Inspector #621 reviewed the planned snack menu and determined that residents were to be offered tea biscuits for the afternoon snack. The planned menu specified a regular tea biscuit for regular and diabetic diets, a tea biscuit with margarine and no raisins for soft/minced diets and a pureed tea biscuit with margarine for pureed diets.

Inspector #621 observed no afternoon snack of tea biscuits in either of the floor serveries. PSW staff located on one of the nursing units were observed to prepare the afternoon nourishment cart with chocolate pudding, egg and tuna salad sandwich quarters and cookies.

During an interview with PSW #116 they reported that no tea biscuits were available on the unit for the afternoon snack but found pudding, sandwiches and cookies available instead.

Inspector #621 met with the DOC to review the planned snack menu and check the snack provisions on the unit. The DOC confirmed that no tea biscuits were available in accordance with the planned snack menu for the afternoon nourishment on a day in June 2016, for two home areas. [s. 71. (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 planned menu items is offered and available at each meal and snack, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for,
(e) menu substitutions that are comparable to the planned menu; O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized food production system in the home, that at a minimum, provided for menu substitutions that were comparable to the planned menu.

Inspector #621 reviewed the planned lunch menu for a day in June 2016, which identified the following menu items:

Starter - Chicken noodle soup
Entrée #1- French toast with sausages
Vegetable #1 - California vegetables
Entrée #2– Tuna melt sandwich
Vegetable #2 – Tossed salad
Dessert #1 – Mixed berries
Dessert #2 – Rainbow sherbet

At the start of the meal service, Inspector #621 made the following observations:

a-French toast was not available in minced or pureed form, and instead Dietary Aide #117 was using pureed bread as a substitute for the minced and pureed textures;

b-Sausages were not available in minced or pureed form, and instead ham was offered as a substitute for the minced and pureed textures;

c-Tuna melt sandwiches were not available in minced or pureed form, and instead the Dietary Aide #117 was serving pureed bread with a portion of minced or pureed tuna as the substitute for texture modified diets; and

d-Tossed salad was not available in minced or pureed form, and instead mashed potatoes and gravy were served as the substitute for the texture modified diets.

During an interview with Dietary Aide #117, they reported to Inspector #621 that the menu items that were available for the lunch meal were prepared in the main kitchen by the cook. Dietary Aide #117 identified that for the residents requiring minced and pureed diet textures, the substitutions prepared were not consistent with the planned menu.

During an interview with the Food Services Supervisor (FSS) #119 on a day in June 2016, they reported that their expectations of staff related to preparation of all menu items was that cooks follow the production schedule and prepared all menu items for all diets and textures in accordance with the planned menu. They also identified it was their expectation that if menu substitutions were required for any reason that they be comparable to the planned menu. On review of the lunch menu for that day in June 2016, the FSS #119 confirmed that:

a) pureed bread was not a comparable substitute for French toast on the pureed diets;

b) minced and pureed ham was not a comparable substitute for sausages on minced or pureed diets;

c) pureed bread with a portion of minced or pureed tuna was not a comparable substitute for tuna melts for minced and pureed diets; and

d) mashed potatoes with gravy was not a comparable substitute for tossed salad on minced and pureed diets. [s. 72. (2) (e)]

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 there is an organized food production system in the home, that at a minimum, provides for menu substitutions that are comparable to the planned menu, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home monitored all residents during meals.

On a day in May 2016, at 1030 hrs, Inspector #616 observed resident #001 and resident #028 seated at two different tables, eating in the dining room, where there were no staff observed in the dining room at that time.

Resident #001 was observed chewing, and eating from their plate of which was one half of a boiled egg, and a piece of toast, without crusts, was served with coffee/tea, a red beverage, and milk.

Resident #028 was observed eating toast, had coffee/tea, a red beverage, and a container of orange slices in front of them.

Inspector #616 observed PSW #133 when they entered the dining room at 1035 hrs. At this time, the Inspector asked the PSW if residents were to be supervised while eating. They stated there should have been a staff in the dining room but was not aware of where they were at this time.

The Inspector reviewed each resident's current care plan. The interventions for resident #001 indicated that they required supervision throughout the meal. Resident #028's care plan intervention indicated supervision of all meals and snacks.

During interviews with RPN #103 and the DOC, they stated that residents were to be supervised during meals. [s. 73. (1) 4.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served until someone was available to provide the assistance required by the resident.

On a day in June 2016, during lunch meal service, Inspector #621 observed resident #037 seated in the dining room from 1255 hrs to 1315 hrs with their meal served to them and no staff providing assistance to this resident.

Inspector #621 reviewed this resident's most current care plan dated June 2016, which identified that resident #037 required assistance from staff.

During an interview with PSW #116 in the dining room at 1315 hrs, they reported to the Inspector that resident #037 required assistance at meals. They confirmed that food and fluids were served to this resident and that the resident should not have been served until a staff person was available to provide the required assistance. [s. 73. (2) (b)]

3. On a day in June 2016, at 1210 hrs, Inspector #577 observed three PSW's handing out lunch meals to residents in the dining room.

At 1215 hrs, an additional three PSW's entered the dining room to assist with meal service.

The following observations were made:

- at 1210 hrs, resident #039 was observed sleeping at a dining room table, with their lunch plate uncovered in front of them and needed to be assisted with their meal. A PSW started to assist the resident at 1215 hrs;

-at 1210 hrs, resident #012 was observed sleeping at a dining room table, with their lunch plate uncovered in front of them and needed to be assisted with their meal. A PSW started to assist the resident at 1215 hrs;

-at 1210 hrs, resident #040 was observed sleeping at a dining room table, with their lunch plate uncovered in front of them and needed to be assisted with their meal. A PSW started to assist the resident at 1220 hrs, and

- at 1210 hrs, resident #041 was observed sleeping at a dining room table, with their lunch plate uncovered in front of them and needed to be encouraged to eat. A PSW

started to assist the resident to eat at 1217 hrs.

During an interview with PSW #134, they reported that they had handed out the meal trays for lunch and further confirmed that the residents who required assistance with their meal should not have been given their meal until someone was available to assist them.

During an interview with the DOC they confirmed that it was the expectation of the home that residents did not receive their meal until staff were available to provide the assistance required by the resident. [s. 73. (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 any resident who requires assistance with eating or drinking is not served until someone is available to provide the assistance required by the resident, specifically in regards to resident #037, #039, #012, #040 and #041, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On a day in May 2016, Inspector #616 observed two utility rooms slightly ajar, and unlocked.

In one room, a clear plastic container of topical prescription creams and ointments labelled with resident prescriptions was observed on the counter top. PSW #139 pulled the door closed, and stated this room should have been closed and locked. The door of another utility room was unlocked and the Inspector observed a portable cart with a clear plastic container of topical prescription creams and ointments labelled with resident prescriptions.

On a day in May 2016, behind the closed bathroom door of a residents room, the Inspector observed a portable cart with a clear plastic container of topical prescription creams and ointments labelled with resident prescriptions and no staff were observed in the area.

PSW #100 stated to the Inspector that PSW's kept the resident's prescriptions creams on their carts, and should not have been left in a resident's room unsupervised. They added that the prescription treatment creams and ointments were to be kept locked in the clean utility rooms.

RN #138 stated the prescription treatment creams in the containers were for each PSW section and were to be locked in the utility rooms. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During Inspector #616's inspection of drug storage within a medication cart, the narcotic box as identified by RPN #103, was unlocked in the bottom drawer of the unlocked medication cart, stored in the locked medication room. They stated that they did not lock the narcotic box when the cart was not in use, nor did they lock the cart while stored in the medication room.

During shift change on a day in June 2016, Inspector #616 observed the narcotic/controlled substance count with off duty RPN #103 and on duty RPN #137. When the count was completed for each of the two medication carts (North and South), the Inspector observed the drugs returned by RPN #103 and RPN #137 to the narcotic boxes in the bottom drawer of each medication cart, without being locked.

RPN #103 stated to the Inspector that they did not lock the narcotic box when the cart was not in use, nor did they lock the cart while stored in the medication room.

RPN #137 stated that their practice was to not lock the narcotic box, or the medication cart, while it was stored in the medication room. They added it probably should be locked, but stated they did not know.

The DOC provided the Inspector with the home's pharmacy guideline related to narcotic and controlled substance storage policy. This updated, document without a reference number, stated that medication storage areas, rooms, and carts were to be kept locked.

During an interview with the DOC, they stated the narcotic box was to be kept locked at all times when not in use, within the locked medication cart, stored in the locked medication room. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During observations of a wound dressing change on a day in June 2016, Inspector #577 noted unsterile technique performed on resident #038. RN #129 did not practice appropriate sterile technique while performing wound care, which allowed for a potential spread of infection.

During an interview with RN #128 and RN #129, they both confirmed that the resident's wound should not have been in direct contact with an unsterile item and sterile technique was not maintained.

During an interview with the DOC they confirmed that infection control practice was not maintained during the resident #038's dressing change and it was the expectation of the home that wound dressing changes were performed with sterile technique. [s. 229. (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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident's rights are fully respected and promoted, and that every resident has been treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

Inspector #621 reviewed Critical Incident report which identified that on a day in October 2015, during a meal service in the dining room, PSW #140 was witnessed by RPN #102 and PSW #115 to make demeaning remarks to resident #001.

A copy of a written letter of warning issued by the DOC to PSW #140 in November 2016, was reviewed by Inspector #621 which identified that PSW #140 acknowledged making the comments to resident #001 and that they were demeaning to the resident. The letter indicated that their actions violated Resident Bill of Rights legislation.

Inspector #621 met with the DOC on a day in May 2016, and they reported that their expectations were that staff treat all residents with dignity and respect, and that the home's investigation confirmed that this did not occur. [s. 3. (1) 1.]

2. The licensee has failed to ensure that resident's rights are fully respected and promoted, and that every resident has been afforded privacy in treatment and in caring for his or her personal needs.

On a day in May 2016, Inspector #577 entered resident #003's room and observed RPN #137 ambulating with the resident to their bathroom. The resident was wearing a top and underwear. The entry door to the residents room was wide open and staff and other residents were walking in the hallway.

During an interview with RPN #137, they reported that the resident had to go to the bathroom, they did not know what to do, and they should have closed the door. [s. 3. (1) 8.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission.

On a day in May 2016, Inspector #577 made the following observations of unlabelled personal items in residents shared bathrooms:

one used, unlabelled bed pan and bath basin in shared bathroom;

one used, unlabelled urinal in shared bathroom;

one used, unlabelled urinal in shared bathroom;

two used, unlabelled urinals in shared bathroom, and

one used, unlabelled hair brush and one used, unlabelled electric toothbrush in shared bathroom.

During a record review of the home's Admission Checklist, it indicated that admission responsibilities included labelling residents belongings and toiletries.

During an interview with the DOC they confirmed that it was the expectation of the home that resident's personal belongings, including urinals, hairbrushes, bedpans and toothbrushes be labelled. [s. 37. (1) (a)]

2. On a day in May 2016, Inspector #616 observed the following unlabelled personal care items stored on the counter of the tub room:

-one used stick deodrant
-one used black comb
-one used white comb with hair observed in teeth of comb

On a day in May 2016, the Inspector observed the following unlabelled personal care products in the shared bathrooms of two resident rooms:

-one used white brush, hair observed in bristles
-one used crest prohealth toothpaste
-used white and pink oral B toothbrush
-used small white comb

On a day in June 2016, the Inspector observed the following unlabelled personal care items stored on the counter and in the left side drawer of tub room:

-one used Speed Stick Ocean Surf deodorant
-one used black handle, grey brush, with hair observed with plastic tipped bristles

During an interview with PSW #100, they stated that personal care products should have been labelled with the resident's names, including the combs.

During an interview with PSW #141, they stated that the resident's personal belongings, and care products should have been labelled with their names. [s. 37. (1) (a)]

Issued on this 3rd day of November, 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) :	DEBBIE WARPULA (577), JENNIFER KOSS (616), JULIE KUORIKOSKI (621)
Inspection No. / No de l'inspection :	2016_333577_0012
Log No. / Registre no:	011642-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 6, 10, Jul 4, Oct 24, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	BETHAMMI NURSING HOME 63 CARRIE STREET, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Meaghan Sharp

To ST. JOSEPH'S CARE GROUP, 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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee will comply with O. Reg. 79 10, s. 15. (1) (a) and ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The licensee shall, for each bed system where bed rails are in use:
(a) Conduct an audit identifying the location and type of bed rails in the home;
(b) Conduct an assessment of each bed system, using a tool specifically designed for that purpose;
(c) Document the results of each assessment, including identification of any deficiencies or safety concerns. Specifically indicate the information upon which the assessment conclusion is based including, but not limited to, assessment of potential zones of entrapment, height and latch reliability and any other applicable safety issues; and
(d) Address each bed system deficiency or safety concern, ensuring that immediate risks are mitigated until permanent resolutions are achieved.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing

practices, to minimize risk to the resident.

During observations on a day in May 2016, Inspector #616 observed resident #005's bed with one upper and lower bed rail in the guard position.

During a record review of the resident's care plan, Inspector #577 noted a nursing intervention indicated to ensure four bed rails were in the guard position when the resident was in bed.

During an interview with PSW #101 they reported that the resident used four bed rails.

During observations on a day in May 2016, Inspector #577 observed resident #003 in bed with upper and lower bed rails in the guard position.

During a record review of the resident's care plan, Inspector #577 noted a nursing intervention that indicated two bed rails in guard position.

During an interview with PSW #100, they reported that the resident used two bed rails.

During observations on two days in May 2016, Inspector #577 observed resident #002 in their bed with one half bed rail in the guard position.

During a record review of the resident's care plan, the Inspector noted a nursing intervention that indicated top bed rail in guard position when resident was in bed.

During an interview with RPN #103 they reported that the resident used a top bed rail. They further reported that they were unsure who was responsible for assessing residents for bed rails.

Inspector #577 conducted an interview with the DOC who reported that the home did not perform bed rail assessments and registered staff determined on admission whether bed rails were needed. The Occupational Therapist (OT) and Physiotherapist (PT) would also make recommendations. The DOC also confirmed that the bed rail assessment tool kit was currently in draft and staff were following the restraint policy. [s. 15. (1) (a)]

(577)

2. During an interview with the DOC, they reported to Inspector #577 that a bed safety audit with recommendations was conducted in 2012.

During a record review of the audit, the Inspector found that between April and May 2012, Shoppers Home Health inventoried 108 beds within the home, which included an inventory of bed frames, mattresses and a full entrapment audit. The audit did not identify bed locations within the home and identified that the following bed systems had failed, as follows:

-Stryker FL-14E1: 12 beds failed in zones 2, 3, 4, 5, 6, 7 and mattress/top of rail height;

-Stryker FL-14E3: 12 beds failed in zones 2, 3, 4, 5, 6, 7 and mattress/top of rail height;

-Bertec FL-13E78: 74 beds failed in zones 2, 3, 4 and mattress/top of rail height; and

-Joerns U770: 6 beds failed in zone 7 and mattress/top of rail height.

During an interview with the DOC they confirmed that according to the audit, 104 beds had failed in 2012 and they were unable to provide any records to confirm that recommendations were made and was not completed as recommended.

Despite the Licensee being aware that there was previous bed system deficiencies as indicated from their 2012 bed safety audit and again, identified non-compliance with r. 15. (1)(a) during the previous 2015 RQI, the Licensee remains non-compliant.

The decision to issue this immediate order was based on the scope which was widespread, the severity which indicated minimal harm/risk or potential for actual harm/risk and the compliance history which included a WN in inspection #2015_333577_0016.

(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2016

Order # / Ordre no : 902

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee will comply with O. Reg. 79 10, r. 110. (2) 2 and ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

The licensee shall:

a) Conduct an audit, to be completed by a registered professional with training and current knowledge of restraints and restraint application, for all restraints used in the home;
b) Record the data collected in the audit including, but not limited to, residents' names, the type of restraints in use, the criteria for use of the restraints (i.e. when in wheelchair,etc.) and the initial assessments of the application of each restraint (i.e. applied correctly, applied incorrectly, in good condition, requires replacement, etc.);
c) Mitigate any risk and address immediate concerns identified during the audit related to the application of each restraint including, but not limited to, loose or improper application positioning;
d) Ensure all required orders, consents, care plans and any other required documentation related to the applications and use of the restraints are accurate, current and complete for each device;
e) Following the initial audit and preliminary assessment by a registered professional with training and current knowledge of restraints and restraint applications, refer any outstanding restraint concerns to an Occupational Therapist (OT) to be further assessed and addressed; and
f) Provide visual illustration of proper restraint application to all direct care staff and registered staff.

Grounds / Motifs :

1. The licensee failed to ensure that the following requirements were met when a resident was being restrained by a physical device under section 31 of the Act: 2: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

During observations of resident #031, Inspector #577 found incorrect application of the resident's lap belt, as follows:

June 1, 2016- resident #031 seated in a tilted wheelchair with a loose fitting lap

belt. Inspector could place a closed fist between the resident and belt. RN #107 confirmed with Inspector that the belt was applied incorrectly and did not have a physician's order.

June 6, 2016- resident #031 seated in a tilted wheelchair with a loose fitting lap belt. Inspector could place a closed fist between the resident and belt. The DOC confirmed incorrect placement with Inspector and reported that they were waiting for occupational therapy to tighten the belt.

During an interview with PT #123, they confirmed that the resident's lap belt was loose and OT assesses and fixes belts.

During an interview with the DOC on June 1, 2016, they confirmed that resident #031 did not have an order for a lap belt restraint from a physician or registered nurse in the extended class. They further confirmed that it was the expectation of the home that staff obtain orders for restraints and belts are applied correctly. (577)

2. During observations of resident #030 on a day in June 2016, Inspector #577 found incorrect application of the resident's front facing apparatus. The Inspector was able to place two closed fists between the resident and the apparatus. PSW #125 confirmed improper placement with the Inspector, and staff tightened the apparatus.

During a record review Inspector could not find a physician's order for the apparatus.

During an interview with RPN #126 and the DOC, they both confirmed that resident #030 did not have an order for an apparatus and the DOC removed the apparatus.

During an interview with the Administrator they confirmed that it was the expectation of the home that residents had properly placed restraints with orders from a physician or registered nurse in the extended class. [s. 110. (2) 1.] (577)

3. A review of the health care records for resident #005 by Inspector #577 identified a physician's order for a rear closing apparatus dated March 2016.

During observations of resident #005, Inspector #577 found incorrect application of the resident's rear closing apparatus, as follows:

On a day in May 2016- resident #005 was seated in their special chair with an apparatus in place and it was loose. The Inspector confirmed the incorrect placement of the apparatus with RPN #127 and they readjusted and tightened the apparatus;

On another day in May 2016, at 1313 hrs and 1607 hrs- resident #005 was seated in their special chair with an apparatus secured around the inside frame and it was loose. Inspector confirmed incorrect placement of the apparatus with PSW #116 and they secured the apparatus to the outside frame of special chair;

On another day in May 2016, at 0926 hrs and 1525 hrs- resident #005 was seated in their special chair with an apparatus secured around the inside of the special chair and it was loose. The Inspector confirmed the incorrect placement of the apparatus with the DOC and they secured the placement of the apparatus underneath the frame of the special chair on the right side;

On another day in June 2016- resident #005 was seated in their special chair with an apparatus secured to the inside of chair and it was loose. The Inspector confirmed the incorrect placement of the apparatus with PSW #116 and they adjusted the apparatus; and

On another day in June 2016- resident #005 was seated in their special chair with an apparatus secured to the inside of the chair and it was loose. Inspector confirmed incorrect placement with the DOC and they secured the apparatus around the resident and underneath the frame of the special chair on the right side.

During an interview with PSW #100 on a day in May 2016, when the resident's apparatus was loose, they reported that they were not sure if the apparatus was applied correctly and told the Inspector to speak with the registered staff. They further reported they have had training on the apparatus but was not sure about proper application. During an interview with RPN #121 and RN #120 they reported that the loose fitting apparatus was applied correctly.

During an interview with the Educator #124 they reported that staff were trained with the least restraint toolkit, annual medworx, requirements for use, but were

not shown application of restraints. They reported that they have not seen any manufacturer's instructions for restraint application for staff.

During an interview with the Manager of Motion Specialties #122, they reported that the standard restraint belts did not contain any information about manufacturer's instructions and arrived in a ziplock style packaging. They further reported that the rear facing seatbelts were bolted to one side of the wheelchair and the belt was secured around the resident at a 45 degree angle behind the back of the wheelchair.

During a record review of the homes policy titled "Least Restraint Program" - LTC 3-100, last revised May 2013, it indicated:

-registered staff will obtain a physician's order or Nurse Practitioner's order for the type and reason for restraint
-registered staff supervises the application of the restraint according to the order and
manufacturer's instructions

During an interview with the DOC, they reported that there were no manufacturing instructions for restraints. They further reported that staff were trained on the least restraints toolkit, annual medworx, requirements for use, but were not shown the application of restraints. They confirmed that it was the expectation of the home that staff apply rear facing seatbelts correctly and securely and resident #005 had incorrect placement on multiple occasions. [s. 110. (2) 1.]

Non-related non-compliance has been previously identified.

The decision to issue this immediate order was based on the scope which was a pattern, the severity which indicated minimal harm/risk or potential for actual harm/risk. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 24, 2016

Order # / Ordre no : 903

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

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0012, CO #902;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall:

a) Ensure that the Director of Care or delegate will verify the correct application of restraints for resident #005 and #039 each time it is applied

b) Create a record of application for resident #005 and #039 which the Director of Care or delegate will document what restraint was applied, time of application and sign off that will ensure correct application in accordance with any instructions specified by the physician or registered nurse in the extended class

c) The above requirements to be performed for two weeks, up to July 21, 2016

Grounds / Motifs :

1. The licensee failed to ensure that the following requirements were met when a resident was being restrained by a physical device under section 31 of the Act: 2: That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.

As part of an immediate order that was issued June 10, 2016, the home was ordered to ensure the correct application of restraints.

During observations of resident #005 on a day in June 2016, Inspector #577 found incorrect application of the resident's apparatus. The resident was seated in their special chair with a loose fitting apparatus. The Inspector placed a closed fist between the resident and the apparatus. The Inspector confirmed incorrect placement of the apparatus with the Administrator and they tightened the apparatus.

During observations of resident #039 on a day in June 2016, Inspector #577 found incorrect application of the resident's apparatus. The resident was seated in their special chair with a loose fitting apparatus. Inspector confirmed incorrect placement of the apparatus with the Administrator and they tightened the apparatus.

During an interview with the Administrator they confirmed that the home provided training to staff regarding apparatus use. They further confirmed that it was the expectation of the home that staff applied apparatus correctly and securely and resident #005 and #039 had incorrect placement of their apparatus. [s. 110. (2) 2.]

The decision to re-issue this immediate order was based on the scope which affected two residents, the severity which indicated minimal harm/risk or potential for actual harm/risk.

Despite the home being issued an immediate order on June 10, 2016, the home remains non-compliant. (577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 21, 2016

Order # / Ordre no : 904

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

Linked to Existing Order / Lien vers ordre existant: 2016_333577_0012, CO #901;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall, for each bed system where bed rails are in use:

a) Conduct an audit identifying the location and type of bed rails in the home for all residents.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

As part of an immediate order that was issued June 10, 2016, the home was instructed to conduct an audit identifying the location and type of bed rails used.

On a day in June 2016, Inspector #577 reviewed the home's audit, titled "Bed Rail Safety Analysis" and "Bed Safety Analysis" and found 52/106 or 49 percent did not indicate the location and type of bed rails used.

During an interview with the Administrator they confirmed that the audit did not include the location and type of bed rails used for 49 percent of those residents.

The decision to reissue this immediate order was based on the scope which was widespread, the severity which indicated minimal harm/risk or potential for actual harm/risk.

Despite the home being issued an immediate order on June 10, 2016, the home remains non-compliant.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 21, 2016

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_333577_0016, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) ensure that resident #027 and any other residents of the long-term care home are protected from abuse by anyone and that residents are not neglected by the licensee or staff.

b) ensure that staff are aware of any residents who exhibit responsive behaviours that may result in injuries to others and that this information is documented in the care plan, including, but not limited to, interventions to address harmful or potentially harmful interactions

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

As part of this Resident Quality Inspection, the inspectors were following up on outstanding compliance order #001 issued during inspection #2015_333577_0016. The licensee was ordered to be in compliance with the following order by December 4, 2015:

"The licensee shall ensure that resident #015 and all other residents are protected from abuse by anyone and shall ensure that all residents are not neglected by staff".

O. Reg. 79/10 defines 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.

A Critical Incident (CI) report was submitted to the Director in February 2016, related to an incident that occurred four days prior. The report identified that resident #026 had abused resident #027 in their bedroom. PSW #130 had reported to RN #131 that they had witnessed resident #027 in bed, with resident #026 also on the bed engaged in an encounter. As per the CI report, resident #027 did not appear to be aware of what had happened.

Inspector #616 reviewed resident #026's health record related to inappropriate responsive behaviours history. Documentation was found within the admission information of the record from 2013 to 2015, that indicated multiple references of this resident's known inappropriate responsive behaviour history toward co-residents and co-patients.

The Inspector reviewed resident #026's the care plan in effect at the time of the incident, dated November 2015. There was no focus, goals, or interventions identified for this resident's known history of inappropriate responsive behaviours. The home failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents.

During an interview with the DOC on a day in June 2016, they stated it was an expectation that staff should have been made aware of the potential risk of inappropriate responsive behaviours from resident #026 to other residents and interventions should have been identified in the resident #026's care plan but had not been.They further reported that staff had no knowledge of resident #026's history of inappropriate responsive behaviour as per the previous health record, and interventions should have been identified in the resident's plan of care but had not been.

Additionally, the home failed to protect residents in the home from abuse by resident #026 as evidenced by non-compliance identified during this inspection related to:
WN #4, LTCHA, 2007 S.O. 2007, c. 8, s. 24 (1) where the home failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to a resident, immediately reported the suspicion and the

information upon which it was based to the Director;
WN #9, LTCHA, 2007 S.O. 2007,c. 8, s. 20 (1) where the licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with; and
WN #12, LTCHA, 2007, O. Reg. 79/20, s. 54 where the licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation that could potentially trigger such altercations. [s. 19. (1)]

Non-compliance have been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 19.(1)

Non-compliance have been previously issued under inspection 2015_333577_0016, including a compliance order served December 4, 2015; pursuant to LTCHA, 2007 S.O. 2007, s. 19.(1)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm and the compliance history which despite previous and continual non-compliance (NC) issued including two compliance orders, NC has continued with this area of the legislation. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_333577_0016, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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. 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. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 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).

Order / Ordre :

The licensee shall:

a) ensure all registered and non-registered staff identify and report all alleged, suspected and witnessed incidents of abuse immediately to the Director

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that 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, immediately reported their suspicion and the information upon which it was based to the Director.

As part of this Resident Quality Inspection, the inspectors were following up on outstanding compliance order #003 issued during inspection #2015_333577_0016. The licensee was ordered to be in compliance with the following order by December 4, 2015:

"The licensee shall ensure that a person who has reasonable grounds to suspect that 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 is to immediately report the suspicion and the information upon which it is based to the Director".

A Critical Incident (CI) report was submitted to the Director in February 2016, related to an incident that occurred in February 2016. The report identified that resident #026 had abused resident #027 in their bedroom. PSW #130 had reported to RN #131 that they had witnessed resident #027 in bed, with resident #026 also on the bed engaged in an encounter. As per the CI report, resident #027 did not appear to be aware of what had happened.

Inspector #616 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents, Reporting and Notifications about Incidents of Abuse or Neglect" - #LTC 5-51, revised February 2016. This policy stated that upon immediate notification of an incident, the Director/designate would notify the Ministry by phone and included contact information for notification during evenings and weekends. It further stated that notification was followed by immediate initiation of the (Ministry) report using the on line Mandatory Critical Incident System form.

During an interview with the DOC on a day in June 2016, they stated they had been notified of the incident within the hour after it occurred but was confused between the reporting timelines of Mandatory Reporting and Critical Incident reporting, and therefore they had not notified the Ministry until four days after the incident occurred. [s. 24. (1)]

Non-compliance had been previously issued under inspection 2015_333577_0004, including a compliance order served August 6, 2015; pursuant to LTCHA, 2007 S.O 2007, s. 24.(1)

Non-compliance had been previously issued under inspection 2015_333577_0016, including a compliance order served December 4, 2015; pursuant to LTCHA, 2007 S.O 2007, s. 24.(1)

The decision to re-issue this compliance order was based on the scope which affected one resident, the severity which indicates actual harm/risk and the compliance history which despite previous non-compliance (NC) issued

including two compliance orders, NC has continued with this area of the legislation. (616)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;
(b) the identification of any risks related to nutrition care and dietary services and hydration;
(c) the implementation of interventions to mitigate and manage those risks;
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall:

a) Ensure that staff are following the weight monitoring system and that residents are weighed on admission and monthly.

b) Ensure the weight monitoring system includes documenting monthly weights in the electronic medical record

Grounds / Motifs :

1. The licensee has failed to ensure that there was a weight monitoring system in place to measure and record each resident's weight on admission and monthly thereafter.

A review of the home's electronic health record by Inspector #621 found multiple residents did not have documented weights for one or more months from

January 2016, to May 2016.

It was determined that during this time period monthly weights were not documented in the electronic health record for the following residents:

-Resident #010 - no weight documented for February 2016
-Resident #012 – no weight documented for January and February 2016
-Resident #013 – no weight documented for February 2016
-Resident #014 – no weight documented for February, March and April 2016
-Resident #015 – no weight documented for January and February 2016
-Resident #016 – no weight documented for January and February 2016
-Resident #017 – no weight documented for February 2016
-Resident #002 – no weight documented for February 2016
-Resident #032- no weight completed in February or March 2016
-Resident #033- no weight completed in February 2016
-Resident #034- no weight completed in February 2016
-Resident #035- no weight completed in February or March 2016
-Resident #036- no weight completed in February or April 2016

A review of the home's policy entitled "Unintentional Weight Loss or Gain" - LTC 5-10, last revised January 2013, identified that residents were weighed on the same scale, at the same time of day each month usually on bath day; and weights are recorded in the electronic record and regularly reviewed by the dietitian.

During an interview on a day in May 2016, PSW #105 identified to Inspector #621 that weights on all residents were obtained on bath days by the 15th of each month and a paper record was kept in the tub room on each unit.

During an interview with RPN #103 they reported that resident weights obtained by PSW staff each month on bath days were entered into the electronic health record by the night shift PSW by the 15th of each month.

During a review of the weight records on the electronic health record, it was identified by RPN #103 that a combined total of 13 monthly weights were missing between January 2016 and May 2016, for resident's #010, #012, #013, #014, #015, #016, #017, and #002.

During an interview with the DOC on a day in May 2016, they identified to

Inspector #621 that it was their expectation that residents had a monthly weight taken and documented in the electronic health record by the night PSW no later than the 15th of the month. The DOC reviewed the weight records for resident #010, #012, #013, #014, #015, #016, #017 and #002 and confirmed that not all monthly weights were recorded in the electronic health record. [s. 68. (2) (e) (i)]

Non-compliance had been previously issued under inspection 2015_333577_0016, including a VPC issued December 4, 2015; pursuant to LTCHA, 2007 S.O 2007, r.68 (2) (e) (i)

The decision to issue this compliance order was based on the scope which affected 13 residents, the severity which indicates minimal harm or potential for actual harm and the compliance history which despite previous non-compliance (NC) issued including one VPC, NC has continued with this area of the legislation. (621)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 07, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
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 6th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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