Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 2, 2017	2017_463616_0007	003910-17	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

JENNIFER KOSS (616), DEBBIE WARPULA (577), SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 15-19, 23-26, 2017.

The following intakes were also inspected:

One Critical Incident System (CIS) report the home submitted related to plan of care.

Two CIS reports the home submitted related to fall with fracture.

Five CIS reports the home submitted related to allegations of resident to resident, and staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Building Services Supervisor, Maintenance-Lead Hand, Recreation Aide, Social Worker/Resident Counsellor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

During the course of the inspection, the Inspectors observed the provision of care and services to residents, resident to resident and staff to resident interactions, conducted daily tours of resident home areas, reviewed resident health care records, various home policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

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
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **10 WN(s)**
- **6 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with 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 secured and locked.

Inspector #617 observed three containers of topical prescription creams in a plastic container on a care cart outside of a resident room. The containers had pharmacy prescription labels identifying the medications, residents' names (resident #003, #018, and #016) and instructions for its application.

At the time of the observations, the Inspector had not observed staff providing care to residents in the adjacent rooms, and noted that there were several residents in this particular hallway.

Two days later, Inspector #617 noted multiple observations of a plastic container with one white container, one small brown plastic bottle and one tube of topical prescription creams on a care cart outside of another resident room within a four hour time frame. Additionally, the following day, these prescription creams were observed outside of a different resident room at three different times within a three hour time frame. The container, bottle, and tube had pharmacy prescription labels identifying the medications, residents' names (resident #019 and #020), and instructions for its application.

At the time of the observations, the Inspector had not observed staff providing care for residents in the adjacent rooms and noted that there were several residents and a family

member in this particular hallway.

Inspector #617 observed a plastic container with two white containers and one tube of topical prescription creams on a care cart outside of a resident room. The containers and tube had pharmacy prescription labels identifying the medications, resident’s name (resident #021) and instructions for its application.

At the time of the observation, the Inspector had not observed staff providing care to residents in the adjacent rooms. One resident and RN #100 with a nursing student were observed in this hallway.

Inspector #617 reviewed Janzen's Pharmacy medication policy titled, "Medication Storage in the Facility - #3.7", dated January 2017, which indicated that all medications dispensed by the pharmacy were to be stored safely, securely and properly, following manufacturer's recommendations and in accordance with federal and provincial laws and regulations. The medication supply was to be accessible only to authorized personnel. Medication storage areas, rooms, and carts were to be kept locked.

During an interview with the Inspector, RN #100 acknowledged that the three topical prescription creams in a plastic container on a care cart in the hallway outside of a particular resident room were not in use and should have been returned to the medication room.

On May 18, 2017, Inspector #617 interviewed PSW #103 and PSW #101 individually who reported to the Inspector that all prescription creams when not in use were to be returned to the medication room and locked. Both PSWs confirmed with the Inspector that prescription creams were not to be left on care carts in the hallway.

During an interview with the Inspector, the Director of Care (DOC) confirmed that treatment creams when not in use were to be returned to the medication room for safe storage and not stored on care carts in the hallway. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

During a staff interview with Inspector #616, RPN #131 stated that resident #006 used a device to aid with elimination.

Inspector #616 observed the resident with this specific aid.

During an interview with the Inspector, the resident stated they did not know why they had the device, or for how long.

The Inspector completed a record review that indicated the use of this device to aid in elimination, including a physician's order.

During the same record review, the Inspector also found that five days after the physician's initial order for the device, a different physician had not re-ordered the device

upon their review the resident’s plan of care.

The Inspector reviewed another documentation source, where specific residents were identified as requiring certain care, and this resident was not identified as using a device to aid in elimination.

The Inspector reviewed documentation from when the device was ordered and in use, and found that on three separate occasions, registered staff had identified adverse effects directly related to the device. For each instance, the physician was made aware and treatment was ordered. However, there was no documentation found pertaining to the planned care of the device.

The Inspector interviewed PSWs #106, #107, and PSW #108. Each PSW was knowledgeable regarding the reason for the device used by resident #006.

During separate interviews with the Inspector, RN #100 and RPN #109 stated to the Inspector that a physician’s order was required for this specific device including the planned care and where this information was documented. RPN #109 stated that these devices required specific care every four to six weeks. The RN and RPN both confirmed that resident #006’s device had not been re-ordered by the physician, and that scheduled care of the device had not been identified or documented in the designated location. Further, they both verified that the required care of the resident's device had not been provided since its use was initiated, approximately 15 weeks (105 days) earlier.

The Inspector reviewed the home’s policy applicable to this device. The policy stated that St. Joseph's Care Group had determined that these devices required specific care every 30 days unless indicated in the care plan to do otherwise.

The Inspector interviewed the DOC on May 19, 2017. They verified that although the resident’s device had been initially ordered, identified through ongoing assessment, and staff were aware of the device, the DOC stated the re-ordering of this device including the planned care, had been missed for this resident. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Inspector #577 observed that resident #004 had missing teeth.

Inspector #617 interviewed resident #004 who reported that they had some of their own teeth and required assistance with care.

A review of resident #004's plan of care indicated the oral hygiene needs as reported by the resident and the level of required assistance by staff twice daily.

Inspector #617 interviewed PSW #112 who reported that resident #004 required assistance with their oral care twice daily. The PSW further explained the level of care that staff provided to the resident. The PSW reported to the Inspector that they documented the oral care provided by staff to resident #004 on the care flow sheet in the Point of Care (POC) documentation system.

Inspector #617 reviewed resident #004's oral care documentation found on POC that indicated which areas of oral care were to be documented and when the oral care was to be provided.

A 23 day period was reviewed in the POC for resident #004. The Inspector found that documentation was missing for all areas of oral care on nine of 23 (39 per cent) occasions, and in another section, on seven of 23 (30 per cent) occasions.

On May 26, 2017, Inspector #617 interviewed the DOC who confirmed that the PSWs were required to document resident #004's oral care on POC. The DOC reviewed resident #004's oral care documentation and confirmed to the Inspector that documentation was missing during the reviewed period. [s. 6. (9) 1.]

3. Inspector #616 interviewed resident #007 regarding the frequency of staff assistance with the resident's oral hygiene care. The resident stated when and how often the staff provided hygiene assistance.

Inspector #617 interviewed resident #007 who reported that they required staff to provide assistance with their oral hygiene needs and that at times, the staff had not provided this assistance.

The Inspector reviewed resident #007's plan of care which indicated that they required staff assistance with oral hygiene care twice daily.

The Inspector interviewed PSW #110 who reported that resident #007 required assistance with oral care. The PSW reported that staff provided oral care to resident

#007 twice daily. The PSW further explained to the Inspector that they documented the oral care provided by staff to resident #007 on the care flow sheet in POC.

A 23 day period was reviewed in the POC for resident #007. The Inspector found that documentation was missing for oral care on 17 of 23 (74 per cent) occasions, and in another section, on seven of 23 (30 per cent) occasions.

On May 26, 2017, Inspector #617 interviewed the DOC, who confirmed that PSWs were required to document resident #007's oral care on POC. The DOC reviewed resident #007's oral care documentation with the Inspector and confirmed that documentation was missing during the reviewed period. [s. 6. (9) 1.]

4. On May 17, 2017, Inspector #577 interviewed resident #011 regarding their oral hygiene needs.

On May 24, 2017, Inspector #617 interviewed resident #011 who specified their oral hygiene needs and that the staff did not provide oral hygiene care more than once a day, and not every day.

The Inspector reviewed resident #011's plan of care which indicated that they required staff assistance for oral hygiene care and that staff were to provide oral care twice daily.

Inspector #617 interviewed PSW #113 who reported that on occasion, resident #011 refused oral care and further reported that staff provided oral hygiene care once daily. The PSW further explained to the Inspector that they documented the oral care provided by staff to resident #011 on the care flow sheet in POC.

A 23 day period was reviewed in the POC for resident #011. The Inspector found that documentation was missing for oral care in both sections on 11 of 23 (48 per cent) occasions.

On May 26, 2017, Inspector #617 interviewed the DOC who confirmed that PSWs were required to document resident #011's oral care on POC. The DOC reviewed resident #011's oral care documentation with the Inspector and confirmed that documentation was missing was missing during the reviewed period. [s. 6. (9) 1.]

5. Inspector #617 interviewed resident #010 regarding their oral hygiene needs and they stated that the oral hygiene assistance from staff was lacking.

During an interview with Inspector #616, they stated that they required the assistance from the staff for certain activities of their oral care. They stated that the staff were always too busy and sometimes the resident would go several days without oral hygiene provided staff.

Inspector #616 reviewed the resident's current plan of care, which identified this specific assistance required by the staff. Also noted were strategies for staff if the resident refused oral care, and the staff were to document if the resident had completed their own care.

During separate interviews with the Inspector, PSWs #114, #115 and #116 confirmed the level of oral care assistance that resident #010 required from staff. They each stated that staff documented the provision of oral care in POC.

A 24 day period was reviewed in the POC for resident #010. The Inspector found that documentation was missing in both sections for oral care on nine of 24 (36 per cent) occasions.

During the Inspector's interview with resident #010 on a particular day in May 2017, they confirmed to the Inspector that they had received oral care during a specific shift when the Inspector found that the documentation was incomplete in the oral care report. Later this same day, PSW #116 verified that they had provided oral care to the resident during two particular shifts but they had not documented it.

On May 26, 2017, during an interview with the Inspector, the DOC stated that staff documented the provision of oral care to each resident in POC. [s. 6. (9) 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 staff and others involved in the different aspects of care required for the device used by resident #006 to aid in elimination, collaborate with each other, in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and in the development of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other; and, to ensure that the provision of the care set out in the plan of care for residents #004, #007, #011, and #010 is documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

On May 18 and 24, 2017, Inspectors #616 and #577 observed the toilet transfer frame in a resident room to be loose and not secured tightly. In addition, on May 25, 2017, Inspector #577 made observations of exposed sharp metal on the bottom frame of the corner wall outside a non-resident room.

On May 25, 2017, Inspector #577 interviewed the Maintenance-Lead Hand (Lead Hand). During this time, the Inspector and the Lead Hand observed the exposed metal on the corner wall outside the non-resident room. The Lead Hand reported that maintenance staff conducted a daily "walk around" and both nursing staff and maintenance staff were responsible to observe areas for repair. They further reported that nursing staff were responsible for processing a maintenance request when repairs were needed.

On May 25, 2017, Inspector #577 reviewed a copy of the home's 'Building Services Directline Work Request' which indicated a procedure for work requests which included repairs, preventative maintenance, installations or inquiries, of a non-urgent nature.

On May 25, 2017, during an interview with the Inspector, the DOC reported that registered and non-registered staff were responsible for initiating a maintenance request and the Directline work request was completed by the ward clerk. The DOC confirmed that a maintenance request had not been processed for the loose toilet transfer frame in the particular resident room or for the exposed metal outside the non-resident room. [s. 15. (2) (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 the home, furnishings and equipment are maintained in safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: 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 written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A Critical Incident System (CIS) report was submitted to the Director on a certain day in May 2017, following Inspector #577's report to the home on this same day, of an allegation of staff to resident abuse, as reported to the Inspector by resident #005.

During an interview with Inspector #577, resident #005 had reported that months ago, a staff member made an accusation that the resident found offensive. The resident also reported that on another occasion, a different staff member made insensitive comments using a raised voice. The resident further stated that these incidents had been reported (unknown to whom) and could not recall when.

Inspector #577 conducted a record review where it was documented that resident #005's family had reported to a registered staff member the insensitive comments made when the resident had expressed that they had felt unwell.

Inspector #577 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, which indicated that all employees and affiliated personnel were required to fulfill their moral and/or legal obligation to report any incident or alleged incident of resident abuse immediately to their Manager/designate. Any employee or board member who was aware of or suspected any of the following must report it as soon as possible in accordance with the reporting procedures with the home:

-abuse of a resident by anyone, or neglect of a resident by an employee or board member of the Home, and

-verbal complaints concerning resident care or operation of the Home.

On May 25, 2017, during an interview with the Inspector, RPN #122 and PSW #106 both reported that any alleged or witnessed abuse should be reported to the DOC.

During an interview with the Inspector, the DOC reported that the alleged incident had not been reported to them and that the registered staff member should have reported it, as per the home's 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 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, to be implemented voluntarily.

WN #5: 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 and of acquiring, in the case of new items.

On May 15, 2017, Inspector #617 observed numerous unlabelled personal care items (hairbrushes and a comb) in the resident tub rooms. The Inspector also observed posted signage in the tub rooms that instructed staff to label all personal care products for use on the right residents.

On May 24, 2017, the Inspector interviewed PSW #110 and PSW #106 separately who both reported that the residents' personal items such as combs and hairbrushes should be labelled if left in the tub room to ensure that they were used on the correct resident.

The Inspector interviewed the DOC who reported that it was the expectation of the home that personal care items used for residents including hairbrushes were to be labelled with the resident's name when stored in the tub rooms and resident bathrooms. [s. 37. (1) (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 each resident of the home has his or her personal items, including personal aides such as dentures, glasses and hearing aides, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #002 was identified as at risk for altered skin integrity.

Inspector #577 reviewed resident #002's physician orders which indicated that the resident had signs of altered skin integrity in a particular area and the frequency of treatment provided by nursing staff. A further review of resident #002's health care records revealed that the resident had on-going altered skin integrity to this area for an extended period of time.

Inspector #577 conducted a record review of the treatments provided to resident #002's altered skin integrity over an approximate six week period. The Inspector found that treatments were completed as ordered, confirmed by staff initials, but there was no description of the area documented.

The Inspector reviewed the home's "Skin and Wound Care Program" dated July 2016, which indicated the following:

-registered staff were to initiate a baseline assessment in the Woundtracker upon discovery of an area of altered skin integrity

-after a dressing change, complete the Woundtracker documentation

-weekly documentation in the Woundtracker included size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition, and equipment being used.

The Inspector conducted a record review for resident #002 and found that the last documentation on the Woundtracker was approximately three months prior, and the area of the altered skin integrity was described.

During an interview with the Inspector, RPN #109 reported that resident #002 had altered skin integrity to this specific area and that the staff documented weekly assessments in the progress notes. During a record review with RPN #109, they confirmed that weekly skin assessments had not been documented and the most recent documentation on the Woundtracker had been completed approximately three months prior.

On May 23, 2017, during an interview the Inspector, the DOC reported that nursing staff were required to document the description of the area of altered skin integrity once weekly in the Woundtracker.

On May 24, 2017, during a separate interview with the Inspector, the DOC confirmed that weekly skin assessments had not been completed as required. They further confirmed that staff should have completed weekly skin assessments on the Woundtracker and signed the assessment tool after each treatment. [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #002 who is exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (4) Subject to subsection (5), the licensee shall ensure that everyone hired as an Administrator after the coming into force of this section,
(a) has a post-secondary degree from a program that is a minimum of three years in duration, or a post-secondary diploma in health or social services from a program that is a minimum of two years in duration; O. Reg. 79/10, s. 212 (4).
(b) has at least three years working experience,
(i) in a managerial or supervisory capacity in the health or social services sector, or
(ii) in another managerial or supervisory capacity, if he or she has already successfully completed the course mentioned in clause (d); O. Reg. 79/10, s. 212 (4).
(c) has demonstrated leadership and communications skills; and O. Reg. 79/10, s. 212 (4).
(d) has successfully completed or, subject to subsection (6), is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time. O. Reg. 79/10, s. 212 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that everyone hired as an Administrator had successfully completed or was enrolled in a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time.

Inspector #616 interviewed the Interim Administrator (AD) on May 24, 2017. They verified to the Inspector that they were hired as the home's Administrator on an Interim basis since February 5, 2017. During an interview with the Interim AD on May 25, 2017, they stated to the Inspector that the incoming permanent Administrator was hired effective May 25, 2017, during this inspection. They also verified that the incoming Administrator as of their hire date of May 25, 2017, had not completed, nor were they currently enrolled in a program in long-term care home administration or long-term care home management. [s. 212. (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 everyone hired as an Administrator after the coming into force of this section, is enrolled in, a program in long-term care home administration or management that is a minimum of 100 hours in duration of instruction time, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of every investigation regarding abuse and neglect was reported to the Director.

The home submitted a CIS report to the Director on a particular day in May 2017, regarding alleged staff to resident abuse involving resident #009. The CIS report indicated that one day earlier, Inspector #617 reported to the DOC an interview they had with resident #009. During that interview with the Inspector, resident #009 had reported that a particular staff member had been abusive and they were too afraid to report it for fear of retaliation.

Inspector #617 reviewed the home's investigation notes which indicated that the allegation of staff to resident abuse was unfounded.

The Inspector reviewed the Ministry of Health and Long-Term Care online reporting portal and found that the home had not amended the CIS report that was submitted on that particular day in May 2017, to include the results of their investigation.

A review of the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect - #LTC5-51", dated February 2016, indicated that a Critical Incident report regarding an incident of suspected resident abuse submitted to the Director was to be finalized and submitted to the MOHLTC Director. The report was to include the results of the investigation and any action in response to the incident of abuse.

During an interview with the Inspector, the DOC confirmed that their investigation had been concluded on that particular day in May 2017, in which the allegation of staff to resident abuse was determined to be unfounded. The DOC further confirmed to the Inspector that they did not report the results of their investigation to the Director. [s. 23. (2)]

WN #9: 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 improper or incompetent treatment of a resident that resulted in harm or risk of harm to the resident, immediately reported the suspicion and information upon which it was based to the Director.

The home submitted a CIS report to the Director on a particular day in May 2017, regarding alleged staff to resident abuse involving resident #009. The CIS report indicated that one day earlier, Inspector #617 reported to the DOC an interview they had with resident #009. During that interview with the Inspector, resident #009 had reported that a particular staff member had been abusive and they were too afraid to report it for fear of retaliation.

Inspector #617 reviewed the home's policy titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect - #LTC5-51", dated February 2016, which indicated that the role and responsibility of the Director/Designate who received the report of alleged resident abuse was to notify the VP Seniors' Health or designate and the MOHLTC Director immediately then initiate an investigation.

During an interview with the Inspector, the DOC who confirmed that on this particular day in May 2017, they became aware of suspected emotional abuse of resident #009. The DOC further explained that on this same day, the Interim Administrator and the DOC had reviewed the Ministry of Health and Long Term Care's guide "Licensee Reporting of Emotional Abuse", dated May 2012, and determined this was not a reportable incident. The DOC further stated that the next day, the DOC and the AD had reconsidered, decided it was reportable, and at that time reported the incident to the Director. [s. 24. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 38. Notification re personal belongings, etc.
Every licensee of a long-term care home shall ensure that a resident or the resident's substitute decision-maker is notified when,
(a) the resident's personal aids or equipment are not in good working order or require repair; or
(b) the resident requires new personal belongings. O. Reg. 79/10, s. 38.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident or the resident’s substitute maker was notified when the resident’s personal aids or equipment were not in good working order or required repair.

On May 16 and 24, 2017, Inspectors #617 and #577 observed the personal mobility aide belonging to resident #008 in disrepair.

The Inspector conducted a record review of resident #008's health care records and could not find any documentation that indicated repairs for this resident's mobility aide had been initiated at any time.

On May 25, 2017, during an interview with the Inspector, the DOC confirmed that mobility aide repairs had not been discussed with resident #008. [s. 38. (a)]

Issued on this 3rd day of August, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER KOSS (616), DEBBIE WARPULA (577), SHEILA CLARK (617)
Inspection No. / No de l'inspection :	2017_463616_0007
Log No. / No de registre :	003910-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 2, 2017
Licensee / Titulaire de permis :	ST. JOSEPH'S CARE GROUP 35 NORTH ALGOMA STREET, P.O. BOX3251, 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 :	Trevor Giertuga

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(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).

Order / Ordre :

The licensee shall ensure that drugs are stored in an area or a medication cart that is secure and locked.

Grounds / Motifs :

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

Inspector #617 observed three containers of topical prescription creams in a plastic container on a care cart outside of a resident room. The containers had pharmacy prescription labels identifying the medications, residents' names (resident #003, #018, and #016) and instructions for its application.

At the time of the observations, the Inspector had not observed staff providing care to residents in the adjacent rooms, and noted that there were several residents in this particular hallway.

Two days later, Inspector #617 noted multiple observations of a plastic container

with one white container, one small brown plastic bottle and one tube of topical prescription creams on a care cart outside of another resident room within a four hour time frame. Additionally, the following day, these prescription creams were observed outside of a different resident room at three different times within a three hour time frame. The container, bottle, and tube had pharmacy prescription labels identifying the medications, residents' names (resident #019 and #020), and instructions for its application.

At the time of the observations, the Inspector had not observed staff providing care for residents in the adjacent rooms and noted that there were several residents and a family member in this particular hallway.

Inspector #617 observed a plastic container with two white containers and one tube of topical prescription creams on a care cart outside of a resident room. The containers and tube had pharmacy prescription labels identifying the medications, resident's name (resident #021) and instructions for its application.

At the time of the observation, the Inspector had not observed staff providing care to residents in the adjacent rooms. One resident and RN #100 with a nursing student were observed in this hallway.

Inspector #617 reviewed Janzen's Pharmacy medication policy titled, "Medication Storage in the Facility - #3.7", dated January 2017, which indicated that all medications dispensed by the pharmacy were to be stored safely, securely and properly, following manufacturer's recommendations and in accordance with federal and provincial laws and regulations. The medication supply was to be accessible only to authorized personnel. Medication storage areas, rooms, and carts were to be kept locked.

During an interview with the Inspector, RN #100 acknowledged that the three topical prescription creams in a plastic container on a care cart in the hallway outside of a particular resident room were not in use and should have been returned to the medication room.

On May 18, 2017, Inspector #617 interviewed PSW #103 and PSW #101 individually who reported to the Inspector that all prescription creams when not in use were to be returned to the medication room and locked. Both PSWs confirmed with the Inspector that prescription creams were not to be left on care carts in the hallway.

During an interview with the Inspector, the Director of Care (DOC) confirmed that treatment creams when not in use were to be returned to the medication room for safe storage and not stored on care carts in the hallway.

The decision to issue a compliance order was based on the severity which was determined to have potential for actual harm to residents, the scope which was determined to be a pattern as the situation occurred in several locations, and the home continues to have ongoing non-compliance in this area of the legislation.

The history of previous non-compliance in this area was identified during the following inspections:

- A voluntary plan of correction (VPC) was issued from the Resident Quality Inspection #2016_333577_0012 served to the home on October 24, 2016;

- A VPC was issued from the Resident Quality Inspection #2015_333577_0016 served to the home to the home on November 27, 2016. (617)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 2nd day of August, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jennifer Koss

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