Ontario

Ministry of Health and Long-Term Care
Long-Term Care Homes Division
Long-Term Inspections Branch

Ministère de la Santé et des Soins de longue durée
Inspection de soins de longue durée
Division des foyers de soins de longue durée

Amended Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Stacey Colameco
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 **X** Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 □ Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	2019_768693_0005
Licensee:	St. Joseph's Care Group 35 North Algoma Street P.O. Box 3251 Thunder Bay ON P7B 5G7
LTC Home:	Bethammi Nursing Home 63 Carrie Street Thunder Bay ON P7A 4J2
Name of Administrator:	Janine Black

Background:
Ministry of Health and Long-Term Care (MOHLTC) Inspectors #542, 625, 693, and 196 conducted an inspection at Bethammi Nursing Home (LTC Home) on the following dates: March 4, 5, 6, 7, 8, 11, 12, 13, 14, 15, 18, 19 and 20, 2019. The inspection was a Resident Quality Inspection (#2019_768693_0005). During the inspection, the inspectors determined that the Licensee, St. Joseph's Care Group (Bethammi Nursing Home or the Licensee) failed to comply with several requirements under the *Long-Term Care Homes Act, 2007* (LTCHA). In accordance with paragraph 4 of s. 152(1) of the LTCHA, a referral to the Director was made following the inspectors' finding of non-compliance under s. 19(1) of the LTCHA and because of the significant number of non-compliance findings issued during the RQI. These included 26

written notifications (WN),13 voluntary plans of corrections (VPC) and 8 compliance orders (CO). The Orders relate to prevention of abuse and neglect, plan of care, safe storage of drugs, bed rails, resident drug regimes, therapy services, and required programs. The inspection revealed that non-compliance was widespread in the LTC home and affected a large number of residents in the LTC home.

As set out in the grounds below, the Licensee failed to provide residents with the treatment, care, services or assistance required for health, safety or well-being, and has demonstrated a pattern of inaction that has jeopardized the health, safety or well-being of one or more residents. As such, I am issuing this Order related to the Licensee's neglect of residents, which is contrary to s. 19(1) of the LTCHA.

Order #001	St. Joseph's Care Group

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to:
The Director is issuing Director's Order #001 after finding that the Licensee failed to comply with subsection 19(1) of the *Long-Term Care Homes Act, 2007* (*LTCHA*). Subsection 19(1) states:

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.

Order:

The licensee must be compliant with s. 19(1) of the *LTCHA*.

Specifically, the Licensee shall,

1) Ensure that residents are not neglected and that they receive the treatment, care, services and assistance required for their health, safety and well-being.

2) Ensure that no more than one resident per week is admitted to Bethammi Nursing Home until compliance with this Director's Order is achieved.

3) In addition to complying with all the Orders issued during the RQI by the compliance due date, prepare, submit and implement the following plans:

    a) A plan to ensure that the LTC home's written policy to promote zero tolerance of abuse and neglect is complied with, as outlined under s. 20(1) of the LTCHA. The

plan shall include training to ensure that all staff understand what constitutes abuse and neglect, and how and when abuse and neglect should be reported to the Director.

b) A plan to ensure that all residents are protected from neglect.
c) A plan to ensure the care set out in the plan of care is provided to residents #013, #023 and #010, as specified in the plan and that the provision of care, the outcomes of care, and the effectiveness of the plan of care are documented.
d) A plan to ensure that written plans of care for all residents set out clear directions to staff and others who provide direct care to the resident.
e) A plan to ensure the security of the drug supply, ensuring all drugs are secured and locked.
f) A plan to ensure bed systems and residents using bed systems are evaluated and assessed. The plan must include a comprehensive review of the LTC home's current practices and guidance documentation for bed system assessment. In addition, the plan shall describe what course of action the LTC home will take in response to the identification of bed system deficiencies.
g) A plan to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident(s) response and the effectiveness of the drugs appropriate to the risk level of the drugs.
h) A plan to ensure that the LTC home's skin and wound care program promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions is implemented in the LTC home.
i) A plan to ensure therapy services for residents of the LTC home are arranged or provided under section 9 of the LTCHA, which is to include occupational therapy and speech-language therapy.

All of the plans must include specific timelines for implementation, accountabilities and deliverables, and are to be submitted to Stacey Colameco, Director by fax to 1-416-327-7603 or courier to 1075 Bay Street, 11th Floor, Toronto, Ontario M5S 2B1, by June 05, 2019.

Grounds:

The Licensee failed to ensure that residents #001, #002, and #003 were not neglected by the licensee or staff.

Neglect is defined under section 5 of Ontario Regulation 79/10 (O. Reg. 79/10) under the LTCHA as the "failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

Inspector #542 reviewed the LTC home's investigation file and identified that residents #001, #002 and #003 were neglected by PSW #104, when they went unattended from 0700 hours until 1300. During this time, PSW #104 failed to provide any care or services to the residents, as per their plan of care. Resident #001, did not receive their breakfast or nourishment. Resident #002 was not given breakfast and was left in bed for six hours. When Resident #002 was discovered by another staff member, they stated, "they were hungry." Resident #003 did not receive their breakfast or nourishment and did not receive another specified type of care as required. As a result of PSW #104's actions of neglect, the residents did not receive breakfast, did not attend the lunch meal service, and were served lunch meal trays in their rooms.

During an interview with the Administrator, the Administrator told the Inspector that two additional CI reports were submitted to the Ministry related to staff to resident neglect of two additional residents by PSW #104 – resident #018 and resident #019. Resident #018 did not receive any care between the hours of 0730 and 1330 and was found to be incontinent with their clothing and mobility aid soiled. The resident's plan of care required that the resident receive a specified continence intervention every two hours. Resident #019 was left soiled for approximately 3 hours when PSW #104 was aware that the resident was incontinent.

The inspector reviewed a CI report that was submitted to the Ministry which identified staff to resident neglect involving resident #006. The resident was found in the morning, in a specific state of dress, lying on top of the blankets, and incontinent.

A written complaint was submitted to the Director regarding resident #017's wound care treatment and health decline since their admission to the LTC home. Four months subsequent to their admission, the resident developed a wound; the Physician was not informed of the wound until three weeks had passed. On a specified date, a wound assessment was initiated related to the resident's wound. The clinical record indicated that the Physician was unaware of the wound until nearly a month had passed, when the Physician received a referral. There were no wound orders received for a specified time, when the Physician reviewed photos of the wound.

During an interview with Inspector #196, complainant #200 alleged neglect by the staff towards resident #017. The complainant reported that they had been told that resident #017 had a wound but were never notified that the wound had worsened. The complainant had not seen the wound themselves until the resident had been transferred to the hospital. The complainant indicated they were shocked that the resident had declined like this, had developed a wound, and that substantial change in condition had occurred.

The licensee did not ensure that therapy services for resident #017 were arranged or provided under section 9 of the LTCHA that included occupational therapy, contrary to O. Reg. 79/10, s. 59(b). A Physician's written order to mitigate wound deterioration in resident #017 indicated that referrals were required for consultation with an Occupational Therapist (OT). Progress notes did not indicate that an OT consultation had occurred as a result of either referral. During an interview

with OT #141, they reported that they had received referrals to see resident #017. OT #141 provided copies of the e-mail referrals and both indicated the referrals were upon the physician's request. The OT further reported that they only had three hours per week in the LTC home and needed to prioritize the referrals and sometimes did not get to see everyone. They further reported that the resident was not assessed in relation to these referrals and no action was taken as a result of these referrals.

The licensee did not ensure that the provision of the care set out in the plan of care was documented for resident #017, contrary to the LTCHA, s. 6(9)1. RD #108 conducted a nutritional assessment for resident #017, based upon a referral by the Director of Care (DOC). On the same date, the RD initiated orders for nutritional supplementation. Together with the Inspector, the RN reviewed the dietary flow sheet for the time period after the nutritional supplementation was ordered and confirmed the supplement was not recorded as being provided at every meal to resident #017 as had been ordered on 11 occasions.

The licensee did not ensure that the LTC home's organized program of nutrition care and hydration included the implementation of interventions to mitigate and manage nutrition care and dietary service risks, contrary to O. Reg. 79/10, s. 68(2)(c). RD #108 conducted a nutritional assessment on resident #017, based upon a referral by the DOC. Subsequently, the RD initiated orders for nutritional supplementation on the same date. During an interview with the DOC, they confirmed the orders were not processed by the registered staff for the nutritional supplement; it was not provided to the resident until one week after the orders were received.

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of resident #017, so that their assessments were integrated and were consistent with and complemented each other. This was contrary to the LTCHA, s. 6(4)(a). The physician specified in a written order that they wanted to be notified of any deterioration in resident #017's wounds, along with photos of the wounds. Subsequent to the order, wound assessments documented that the resident's wounds deteriorated; the physician was not notified as ordered. During an interview with the DOC, they reported to the Inspector that resident #017's wound had worsened and the physician should have been notified.

Further to LTCHA s. 6(4)(a), with regards to collaboration related to addressing resident #017's pain, the DOC reported to the Inspector that they would expect some record of the communication of the resident's pain to the registered staff. The DOC then confirmed the PSW documentation of observed resident pain, had increased since the last pain assessment and was not re-assessed. While resident #017 was experiencing increased pain, it was incorrectly documented that the resident was comfortable with the current pain control.

The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan, contrary to the LTCHA, s. 6(7). The health care records for resident #017

were reviewed for information regarding the provision of wound care. A Wound Assessment Tool was initiated for a wound on a specified date. The care plan included an intervention for the application of a dressing as ordered by a physician. The physician's orders indicated dressing changes were to be completed on a specified frequency. The Wound Assessment Tool did not have documented dressing changes or a wound assessment completed on six occasions.

As required by O. Reg. 79/10, s. 48(1), the licensee did not ensure that the following interdisciplinary programs were developed and implemented in the home: A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. The licensee's skin and wound program for the Prevention of Skin Breakdown indicated that an assessment was to be competed quarterly and more often as required, and that risk mitigation strategies and interventions were to be implemented to address areas of risk or actual skin impairment. During an interview with the DOC, they confirmed to the inspector, upon review of the Wound Assessment Tool for resident #017, that the physician ordered dressing changes, were not documented as completed on six occasions; concluding, that the dressing changes had not been done.

Further related to O. Reg. 79/10, s. 48(1), during an interview with the Best Practice RN, they reported to the inspector that a nurse's recommendation, an MD order, or OT referral, could initiate the use of an air mattress or therapeutic surface for resident #017’s bed as two assessments identified a referral for the use of a therapeutic surface. The Best Practice RN indicated that the use of a therapeutic surface should have been included in resident #017's care plan if it was used as an intervention to promote wound healing. They confirmed, after a review of the health care records, that a therapeutic surface was not utilized for resident #017, although the LTC home's wound care program advised staff to do so.

The RQI inspection revealed a widespread nature of non-compliance within the LTC home. Following the RQI, 26 written notifications (WN) were issued, including 13 voluntary plans of corrections (VPC) and 8 compliance orders (CO) (CO#001, #002, #003, #004, #005, #006, #007 and #008).

The eight compliance orders, including the Licensee’s compliance history, also demonstrate the Licensee’s failure to provide residents with the treatment, care, services or assistance required for health, safety or well-being, and reveal the Licensee’s pattern of inaction that has jeopardized the health, safety or well-being residents. Specifically, as determined during the RQI:

- **LTCHA, s. 20 (1) Not ensuring the abuse policy was complied with**
    - Residents #001, #002, and #003 were neglected for not having been provided with specified care for an entire shift. Another incident reported by the LTC home described that resident #006 was not provided with care during an entire night shift and was found in the morning with in a specific state of dress, incontinent, laying on top of their blankets; in addition, staff failed to appropriately report the incident of neglect.

- **LTCHA, s. 6 (7) Plan of Care** – Not ensuring that the care set out in the plan of care was provided to the resident as specified in the plan.
    - A review of resident #023's health care record included a Speech Pathologist recommendation for a specific diet type. The recommendations of the diet type were not implemented for the resident.
    - Resident #013 was identified to require a specific diet type. During an interview, the DOC confirmed that the diet type was not provided to the resident as specified.
    - Resident #010 was assessed and it was determined that a specific intervention was not required. The resident was observed by the Inspector to have the intervention initiated. The Administrator confirmed that the intervention was not to be used, as per the assessment.
- **O. Reg. 79/10, s. 129 Safe Storage of Drugs** – Not ensuring drugs were locked in a secure area.
    - During the course of inspection, the inspectors observed numerous instances of topical medication unsecured in resident rooms and common areas.
    - The LTC home has been issued this same finding during three consecutive Resident Quality Inspections, despite previous orders, the licensee has not sustained compliance.
- **O. Reg. 79/10, s. 15 Bed Rails & Bed System Assessment**
    - 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 an interview with the Administrator, they reviewed the Bed Safety Checklists completed for 2018 and acknowledged that not all 112 resident beds in the home had records of assessment of latch reliability, and that the Bed Safety Checklists did not identify that bed rail height had been assessed. The Administrator also stated that nursing staff completed entrapment zone testing, although they did not have any specialized training to do so and did not use a bed system entrapment tool to assess the beds.
- **O. Reg. 79/10, s. 134 Drug Regimes**
    - The LTC home failed to monitor the effectiveness of medication administration; the inspector discovered 4951 entries (on 496 pages) where staff failed to document medication effectiveness.
- **O. Reg. 79/10, s. 48 Falls Prevention Skin & Wound, Continence Care**
    - Residents who experienced falls failed to receive post fall assessment on a widespread basis, despite knowledge of staff that a specified injury was sustained.
- **O. Reg. 79/10, s. 59 Therapy services**
    - A resident with wound care needs failed to receive OT services as the Occupational Therapist indicated they only had three hours per week to see everyone.

In January of 2019, during inspection 2019_703625_0002, two Directors Referrals were issued to the LTC home. Non-compliance under s. 6(1)(c) and s. 6(9) under the LTCHA were issued when the licensee failed to provide clear direction to staff, and documentation of the provision of care with

respect to the residents' plans of care. This represented a third consecutive non-compliance issued to the Licensee for both orders.

On April 25, 2018, a Director's Order was issued to the licensee requiring an external consultant with extensive experience in managing or operating a long-term care home, to conduct a review and make recommendations for improvement in numerous deficient care areas. A report regarding the review was provided to the Director on June 15, 2018; as well, a plan for action was submitted to the Director on June 29, 2018. Despite these actions, pervasive and widespread non-compliance continued to be evident during subsequent inspections, as evidenced during the RQI.

As Director, I have relied on the evidence gathered in Inspection #2019_768693_0005. I have reviewed the inspection report, the Orders issued, and the evidence collected by the inspectors. Additionally, I have considered the Licensee's compliance history, and the licensee's inability to achieve and sustain compliance. Based on this and the grounds included this Order, I have determined that this Director's Order is warranted given the Licensee's non-compliance with 19(1) of the LTCHA related to neglect of residents in the LTC home and the significant number of non-compliance findings from the RQI, which have jeopardized the health and well-being of residents.

The Licensee has failed to ensure that residents were not neglected by licensee or staff. Furthermore, they have not put strategies in place to effectively comply with the requirements of the LTCHA to ensure the safety of residents in the LTC home and any future residents to be admitted to the LTC home.

The decision to issue this Director's Order was based on the scope and severity of non-compliance, and the LTC home's compliance history over the past 36 months. The scope is identified as widespread in the LTC home and represents systemic failure that affects or has the potential to negatively affect a large number of the LTC home's residents. The severity is determined to be actual harm or risk of actual harm. The Licensee's history of non-compliance is extensive; despite numerous Written Notifications, Voluntary Plans of Correction, and Compliance Orders, repeated and ongoing non-compliance with requirements under the LTCHA continue to occur at Bethammi Nursing Home.

This order must be complied with by:	August 22, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100

Toronto, ON
M5S 2T5

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.

Amended on this day of June 05, 2019.	
Signature of Director:	
Name of Director:	Stacey Colameco

Version date: 2017/02/15