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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## 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 |
|---|---|---|---|
| Sep 17, 2018 | 2018_657681_0015 | 005684-18 | Resident Quality Inspection |

### Licensee/Titulaire de permis

North Shore Health Network (fka Blind River District Health Centre)
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

North Shore Health Network - LTC Unit
525 Causley Street P.O. Box 970 BLIND RIVER ON P0R 1B0

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

STEPHANIE DONI (681), TIFFANY BOUCHER (543)

### 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): July 23-27, 2018.**

**The following intakes were inspected during this Resident Quality Inspection:**

**-One intake related to CO #001 from Inspection report #2017_655679_0013, s. 19 (1) of the Long-Term Care Homes Act (LTCHA), specific to the home's duty to protect residents from abuse and neglect.**

**-One intake related to CO #002 from Inspection report #2017_655679_0013, s. 20 (1) of the LTCHA, specific to ensuring the home's zero tolerance of abuse and neglect policy is complied with.**

**-One intake related to an allegation of resident to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Chief Nursing Executive (CNE), Director of Care (DOC), Manager of Nutrition and Food Services, Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Dietary Aides, family members, and residents.**

**The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**

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

- **8 WN(s)**
- **6 VPC(s)**
- **2 CO(s)**
- **0 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 |
|---|---|---|---|
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2017_655679_0013 | 543 |
| LTCHA, 2007 S.O. 2007, c.8 s. 20. (1) | CO #002 | 2017_655679_0013 | 543 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 48. Required programs**

**Specifically failed to comply with the following:**

**s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:**
**1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).**
**2. 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. O. Reg. 79/10, s. 48 (1).**
**3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).**
**4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following interdisciplinary programs were developed and implemented in the home: a continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable.

a) Resident #004 was identified as being incontinent through a Minimum Data Set (MDS) assessment. Please refer to WN #2.

During an interview with resident #004's family member, they stated that a specified incontinence product was recommended by staff at the home for resident #004. Resident #004's family member stated that the home advised them that the family would have to provide the specified incontinence product at their own expense.

During an interview with PSW #115, they stated that the home did not supply a specified type of incontinence product and that these products were supplied by family members. PSW #115 stated that they were unaware of any resident in the past year or two who had the specified incontinence product supplied by the home.

During an interview with RPN #104, they stated that the home did not supply a specified type of incontinence product. RPN #104 stated that the home had some residents who used the specified incontinence product, but that they were supplied by the resident's families.

During an interview with the DOC, they stated that the specified incontinence product was typically supplied by the residents' families. The DOC stated that the specified incontinence product was presented to residents' families as an option that they would have to provide.

b) Resident #009 was identified as being incontinent through a MDS assessment. The MDS assessment indicated resident #009's continence status had changed since their previous MDS assessment. Please refer to WN #2.

Inspector #681 reviewed resident #009's electronic medical record, which indicated that resident #009's last continence assessment was completed on a specified date.

During an interview with the DOC, they stated that continence assessments were completed on admission and every six months thereafter. The DOC stated that a continence assessment would "typically" be completed if the resident experienced a change in continence status, but that they were not certain if this was always being completed. The DOC also stated that they were uncertain about what was indicated in the home's continence care program related to when continence assessments were to be completed.

The Inspector requested a copy of the home's continence care program from the CNE and was provided with a two page policy titled "Continence Care Protocol".

During an interview with the DOC, they stated that the home did not have a continence care program in place and the only policy related continence care was the "Continence Care Protocol". [s. 48. (1) 3.]

***Additional Required Actions:***

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

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**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. (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 the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #003 was identified as being incontinent through a MDS assessment.

The Inspector reviewed resident #003's care plan, which indicated that the resident required a specified incontinence product and that specific continence interventions were to be implemented.

The Inspector reviewed the progress notes in resident #003's electronic medical record, which included a Multidisciplinary Care Conference Note which indicated that different continence interventions were to be implemented.

During an interview with PSW #108, they stated that resident #003 was incontinent and that the resident used specified incontinence products. PSW #108 stated that a specific continence intervention was to be implemented at a particular time of the day for resident #003.

During an interview with PSW #111, they stated that resident #003 was incontinent and that they required a specified type of incontinence product. PSW #111 also stated that resident #003 refused to participate in a specified continence intervention.

During an interview with PSW #115, they stated that resident #003 required a specified incontinence product. PSW #115 also stated that resident #003 refused to participate in a specified continence intervention so it was no longer being implemented. PSW #115 reviewed the resident's current care plan with Inspector #681 and acknowledged that the

care plan had not been updated to reflect the resident's current status.

During an interview with RPN #104, they indicated resident #003 was incontinent. RPN #104 stated that they spoke with a PSW who routinely provided care to resident #003 and they stated that resident #003 required a specified incontinence product. RPN #104 stated that the resident's care plan was not updated to reflect the changes, and that resident #003's care plan was reflective of the resident's status when their quarterly multi-disciplinary review was completed.

During an interview with the DOC, they indicated that the home's expectation was that resident care plans be updated by the RPN with any changes in required incontinence products once the change had been trialed and was determined to be effective. [s. 6. (10) (b)]

2. Resident #004 was identified as being incontinent through a MDS assessment.

The Inspector reviewed resident #004's care plan, which indicated that the resident was incontinent and that they required a specified type of incontinence product.

The Inspector reviewed the progress notes in resident #004's electronic medical record, which included a Multidisciplinary Care Conference Note. The Multidisciplinary Care Conference Note indicated that resident #004 required a specified incontinence product and that a specified continence intervention was to be implemented.

During an interview with PSW #108, they stated that resident #004 was incontinent and that a specified continence intervention was to be implemented. PSW #108 stated that resident #004 required a specified incontinence product that the family provided during the day and a different incontinence product at night.

During an interview with PSW #111, they stated that resident #004 was incontinent and that a specified continence intervention was to be implemented. PSW #111 stated that resident #004 used a specified incontinence product during the day and a different incontinence product at night.

During an interview with PSW #115, they stated that resident #004 used a specified incontinence product during the day and a different incontinence product at night. PSW #115 reviewed resident #004's care plan with Inspector #681. PSW #115 acknowledged that the resident's care plan needed to be updated to reflect the changes in resident

#004's care.

During an interview with the DOC, they indicated that the home's expectation was that resident care plans be updated by the RPN with any changes in required incontinence products once the change had been trialed and was determined to be effective. [s. 6. (10) (b)]

3. Resident #009 was identified as being incontinent through an MDS assessment.

The Inspector reviewed resident #009's care plan, which indicated that resident #009 was incontinent and that they used a specified incontinence product.

The Inspector reviewed the progress notes in resident #009's electronic medical record, which included a Multidisciplinary Care Conference Note, which indicated that resident #009 used a specified incontinence product and that a specific continence intervention was to be implemented.

During an interview with PSW #111, they stated that resident #009 was incontinent and that they required a specified incontinent product that the family provided during the day. However, when the specified incontinence product was not provided by the resident's family, a different incontinence product was used by resident #009. PSW #111 also stated that resident #009 used another specified incontinence product at night. The Inspector reviewed resident #009's current care plan with PSW #111. PSW #111 verified that the care plan did not reflect the incontinence products that the resident was using during the day and acknowledged that the care plan had not been updated to reflect resident's current care needs.

During an interview with PSW #115, they stated that resident #009 used a specified incontinence product during the day and a different incontinence product at night. The Inspector reviewed resident #009's current care plan with PSW #115. PSW #115 stated that the care plan needed to be updated to reflect that the specified incontinence products that resident #009 required.

During an interview with the RAI Coordinator, they stated that they believed that resident #009 used a specified incontinence product during the day and at night and that this was a recent change. The RAI Coordinator verified that resident #009's care plan indicated incorrect incontinence interventions.

During an interview with the DOC, they indicated that the home's expectation was that resident care plans be updated by the RPN with any changes in required incontinence products once the change had been trialed and was determined to be effective. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #3: 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:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

According to the Personal Health Information Protection Act, 2004, personal health information refers to identifying information about an individual in oral or recorded form, if the information relates to the physical or mental health of the individual or if it relates to the providing of health care to the individual.

On July 24, 25, and 26, 2018, Inspector #681 observed that there was a resident diet list posted on a bulletin board in the home’s main dining room. The resident diet list included the following information: resident names, diet order, diet texture, fluid consistency, dietary interventions, allergies/intolerances, and level of required eating assistance.

During an interview with Dietary Aide #106, they stated that the resident diet list was always posted on the bulletin board in the dining room so that it could be referenced by PSWs and RPNs during meal service.

During an interview with RPN #104, they stated that they did not believe that the resident diet list contained personal health information because it did not identify diagnoses or the reason for a specific dietary intervention. RPN #104 acknowledged that a specified family member regularly went up to the servery to get a particular resident's meal tray and that the information on the resident diet list would be visible to this family member and any other residents or visitors who went up to the servery.

Inspector #681 reviewed the home’s policy titled “Confidentiality and Security of Personal Health Information and Personal Information” dated August 2017, which indicated personal health information and personal information was to be maintained in the strictest of confidence and was not be shared with unauthorized persons.

During an interview with the Manager of Nutrition and Food Services, they stated that a resident’s diet order, diet texture, and fluid consistency would be considered personal health information. The Manager of Nutrition and Food Services acknowledged that the resident diet list was posted in a public location in the dining room and was visible to both residents and visitors who were in the dining room.

During an interview with the CNE, they stated that a resident’s diet order, texture, and fluid consistency would be considered personal health information and that this type of information should not be posted in a public location within the home. [s. 3. (1) 11. 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 the right of every resident to have his or her personal health information kept confidential in accordance with the Personal Health Information Protection Act is fully respected and promoted, to be implemented voluntarily.***

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**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 the 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 had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A critical incident (CI) report was submitted to the Director, which indicated that on a particular date, resident #001, who had a history of inappropriate behaviours, attempted to touch co-residents and spoke to a co-resident in an inappropriate manner.

Inspector #543 reviewed the home's "Abuse of Patients or Residents" policy. The policy indicated that any employee, who witnessed, was aware of, or suspected resident abuse shall report it immediately to the manager or designate. The manager will immediately report the incident by completing a critical incident report online during business hours. If after hours, the Long-Term Care Home staff RPN will contact the after-hours pager number as soon as the incident was known.

Inspector #543 reviewed a progress note in resident #001's electronic medical record, which indicated that on a particular date, resident #001 was moved away from all other residents because they attempted to touch other residents. Resident #002 was also heard making inappropriate comments to resident #001.

During an interview with Inspector #543, the CNE verified that the RPN, who was aware of the incident on that particular date, was responsible for reporting the incident and that they should have reported the incident to the Director via the after hours line on that date. [s. 24. (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 ensure that any 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 risk of harm has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every plan of care must be based on, at a minimum, an interdisciplinary assessment of a resident's mood and behaviour patterns, including wandering, and any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Compliance Order (CO) #001 was issued to the home during inspection #2017_665679_0013, related to s. 19 (1) of the Long-Term Care Homes Act. The home was ordered to ensure that all residents were protected from abuse by anyone. The compliance due date of this order was January 12, 2017.

Resident #004 was identified as being incontinent through a MDS assessment. Inspector #681 reviewed the progress notes in resident #004's electronic medical record and noted that resident #004 was exhibiting inappropriate behaviours. A progress note on a specific date indicated that resident #004 was observed acting inappropriately towards resident #009. A second progress note on another specified date, indicated that resident #004 made inappropriate comments to resident #009. A third progress note on a specific date indicated that resident #004 made inappropriate comments to resident #010.

Inspector #543 reviewed resident #004's progress notes and identified that the resident demonstrated inappropriate behaviours on seven separate occasions.

Inspector #543 reviewed resident #004's care plan and noted that it did not address any behaviours that the resident exhibited.

Inspector #543 interviewed PSW #111 who verified that resident #004 had demonstrated inappropriate behaviours and that the frequency of the behaviours had been increasing.

Inspector #543 interviewed RPN #104 who verified that resident #004 had demonstrated inappropriate behaviours towards staff.

Inspector #543 interviewed the RAI Coordinator who indicated that responsive behaviours should be identified in the resident's care plan. The RAI Coordinator verified that resident #004's care plan did not identify a focus, goals or interventions related to the resident's inappropriate behaviours.

The Inspector interviewed the DOC who verified that any form of behaviour a resident displayed should be identified in the resident's care plan.

The Inspector interviewed the CNE who indicated that the expectation was that the resident's care plan would identify any form of responsive behaviours and that the care plan should clearly indicate the form of behaviour. [s. 26. (3) 5.]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every plan of care must be based on, at a minimum, an interdisciplinary assessment of a resident's mood and behaviour patterns, including wandering, and any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

**Specifically failed to comply with the following:**

**s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:**
**1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).**
**2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).**
**3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).**
**4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following were developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required.

Resident #004 was identified as being incontinent through a MDS assessment. Inspector #681 reviewed resident #004's electronic medical record and noted progress notes which indicated that resident #004 was exhibiting inappropriate behaviours. Inspector #543 identified non-compliance related to section 26 of the Ontario Regulation 79/10, specific to behaviours. Please refer to WN #5.

On July 27, 2018, Inspector #543 requested a copy of the homes Responsive Behaviours program, but the CNE and DOC were unable to provide such program.

Inspector #543 interviewed the DOC and CNE who both verified that the home does not have a Responsive Behaviours program or policy. The DOC indicated that the home referred residents who exhibited responsive behaviours to the Behavioural Supports Ontario (BSO) program who followed their own protocols. [s. 53. (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 following were developed to meet the needs of residents with responsive behaviours: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required, to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation, and the date that the changes and improvements were implemented was promptly prepared.

Inspector #543 reviewed the home's policy titled "Abuse of Patients or Residents", that was last updated January 2018.

The Inspector requested a copy of the home's annual evaluation of the "Abuse of Patients or Residents" policy. During an interview with the CNE, they verified that the home's "Abuse of Patients and Residents" policy had been reviewed and revised, however there was no written record to support any changes or improvements that were implemented. [s. 99. (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 a written record of everything provided for in the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, including the date, the names of the persons who participated in the evaluation, and the date that the changes and improvements were implemented is promptly prepared, to be implemented voluntarily.***

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes or improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that once in every calendar year, they conducted an evaluation to determine the effectiveness of the policy to minimize the restraining of residents, and identify what changes and improvements were required to minimize restraining and ensure that restraining was done in accordance with the Act and Regulation.

Inspector #543 requested a copy of the licensee's annual evaluation of the "Restraint/PASD" policy, and the CNE was unable to provide this documentation.

During an interview with the CNE, they verified that the home's "Restraint/PASD" policy had not been reviewed or updated since 2013. [s. 113. (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 at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy to minimize the restraining of residents, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulation, to be implemented voluntarily.***

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**Issued on this 18th day of September, 2018**

**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) :** | STEPHANIE DONI (681), TIFFANY BOUCHER (543) |
| **Inspection No. / No de l'inspection :** | 2018_657681_0015 |
| **Log No. / No de registre :** | 005684-18 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Sep 17, 2018 |
| **Licensee / Titulaire de permis :** | North Shore Health Network (fka Blind River District Health Centre)<br>525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0 |
| **LTC Home / Foyer de SLD :** | North Shore Health Network - LTC Unit<br>525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Lisa High |

To North Shore Health Network (fka Blind River District Health Centre), you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. 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.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

**Order / Ordre :**

The licensee must be compliant with s. 48 (1) (3) of the Ontario Regulation 79/10.

Specifically the licensee must:

a) Ensure that a continence care and bowel management program to promote continence and ensure that residents are clean, dry, and comfortable is developed and implemented in the home.

b) Ensure that the continence care and bowel management program meets the requirements identified in the Ontario Regulation 79/10, s. 51.

c) Ensure that residents are provided with a range of continence care products that are based on their individual assessed needs.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the following interdisciplinary programs

were developed and implemented in the home: a continence care and bowel management program to promote continence and to ensure that residents were clean, dry and comfortable.

a) Resident #004 was identified as being incontinent through a Minimum Data Set (MDS) assessment. Please refer to WN #2.

During an interview with resident #004's family member, they stated that a specified incontinence product was recommended by staff at the home for resident #004. Resident #004's family member stated that the home advised them that the family would have to provide the specified incontinence product at their own expense.

During an interview with PSW #115, they stated that the home did not supply a specified type of incontinence product and that these products were supplied by family members. PSW #115 stated that they were unaware of any resident in the past year or two who had the specified incontinence product supplied by the home.

During an interview with RPN #104, they stated that the home did not supply a specified type of incontinence product. RPN #104 stated that the home had some residents who used the specified incontinence product, but that they were supplied by the resident's families.

During an interview with the DOC, they stated that the specified incontinence product was typically supplied by the residents' families. The DOC stated that the specified incontinence product was presented to residents' families as an option that they would have to provide.

b) Resident #009 was identified as being incontinent through a MDS assessment. The MDS assessment indicated resident #009's continence status had changed since their previous MDS assessment. Please refer to WN #2.

Inspector #681 reviewed resident #009's electronic medical record, which indicated that resident #009's last continence assessment was completed on a specified date.

During an interview with the DOC, they stated that continence assessments were completed on admission and every six months thereafter. The DOC stated

that a continence assessment would "typically" be completed if the resident experienced a change in continence status, but that they were not certain if this was always being completed. The DOC also stated that they were uncertain about what was indicated in the home's continence care program related to when continence assessments were to be completed.

The Inspector requested a copy of the home's continence care program from the CNE and was provided with a two page policy titled "Continence Care Protocol".

During an interview with the DOC, they stated that the home did not have a continence care program in place and the only policy related continence care was the "Continence Care Protocol".

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm to the residents of the home. The scope of the issue was a level three, as it related to all the residents in the home. The home had a level three compliance history, as they had previous related non-compliance with section 51 (2) (a) of the Ontario Regulation 79/10 that included a voluntary plan of correction (VPC) issued October 13, 2015, (#2015_395613_0015). (681)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 01, 2018

**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

**Order / Ordre :**

The licensee must be compliant with s. 6 (10) b of the Long Term Care Homes Act (LTCHA).

Specifically the licensee must:

a) Ensure that the resident's plan of care be reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary.

b) Complete a care plan review for all residents who are incontinent to ensure that their care plans accurately identify the continence care interventions that the resident is assessed to require.

**Grounds / Motifs :**

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

Resident #003 was identified as being incontinent through a MDS assessment.

The Inspector reviewed resident #003's care plan, which indicated that the resident required a specified incontinence product and that specific continence

interventions were to be implemented.

The Inspector reviewed the progress notes in resident #003's electronic medical record, which included a Multidisciplinary Care Conference Note which indicated that different continence interventions were to be implemented.

During an interview with PSW #108, they stated that resident #003 was incontinent and that the resident used specified incontinence products. PSW #108 stated that a specific continence intervention was to be implemented at a particular time of the day for resident #003.

During an interview with PSW #111, they stated that resident #003 was incontinent and that they required a specified type of incontinence product. PSW #111 also stated that resident #003 refused to participate in a specified continence intervention.

During an interview with PSW #115, they stated that resident #003 required a specified incontinence product. PSW #115 also stated that resident #003 refused to participate in a specified continence intervention so it was no longer being implemented. PSW #115 reviewed the resident's current care plan with Inspector #681 and acknowledged that the care plan had not been updated to reflect the resident's current status.

During an interview with RPN #104, they indicated resident #003 was incontinent. RPN #104 stated that they spoke with a PSW who routinely provided care to resident #003 and they stated that resident #003 required a specified incontinence product. RPN #104 stated that the resident's care plan was not updated to reflect the changes, and that resident #003's care plan was reflective of the resident's status when their quarterly multi-disciplinary review was completed.

During an interview with the DOC, they indicated that the home's expectation was that resident care plans be updated by the RPN with any changes in required incontinence products once the change had been trialed and was determined to be effective. [s. 6. (10) (b)]

2. Resident #004 was identified as being incontinent through a MDS assessment.

The Inspector reviewed resident #004's care plan, which indicated that the resident was incontinent and that they required a specified type of incontinence product.

The Inspector reviewed the progress notes in resident #004's electronic medical record, which included a Multidisciplinary Care Conference Note. The Multidisciplinary Care Conference Note indicated that resident #004 required a specified incontinence product and that a specified continence intervention was to be implemented.

During an interview with PSW #108, they stated that resident #004 was incontinent and that a specified continence intervention was to be implemented. PSW #108 stated that resident #004 required a specified incontinence product that the family provided during the day and a different incontinence product at night.

During an interview with PSW #111, they stated that resident #004 was incontinent and that a specified continence intervention was to be implemented. PSW #111 stated that resident #004 used a specified incontinence product during the day and a different incontinence product at night.

During an interview with PSW #115, they stated that resident #004 used a specified incontinence product during the day and a different incontinence product at night. PSW #115 reviewed resident #004's care plan with Inspector #681. PSW #115 acknowledged that the resident's care plan needed to be updated to reflect the changes in resident #004's care.

During an interview with the DOC, they indicated that the home's expectation was that resident care plans be updated by the RPN with any changes in required incontinence products once the change had been trialed and was determined to be effective. [s. 6. (10) (b)]

3. Resident #009 was identified as being incontinent through an MDS assessment.

The Inspector reviewed resident #009's care plan, which indicated that resident #009 was incontinent and that they used a specified incontinence product.

The Inspector reviewed the progress notes in resident #009's electronic medical

record, which included a Multidisciplinary Care Conference Note, which indicated that resident #009 used a specified incontinence product and that a specific continence intervention was to be implemented.

During an interview with PSW #111, they stated that resident #009 was incontinent and that they required a specified incontinent product that the family provided during the day. However, when the specified incontinence product was not provided by the resident's family, a different incontinence product was used by resident #009. PSW #111 also stated that resident #009 used another specified incontinence product at night. The Inspector reviewed resident #009's current care plan with PSW #111. PSW #111 verified that the care plan did not reflect the incontinence products that the resident was using during the day and acknowledged that the care plan had not been updated to reflect resident's current care needs.

During an interview with PSW #115, they stated that resident #009 used a specified incontinence product during the day and a different incontinence product at night. The Inspector reviewed resident #009's current care plan with PSW #115. PSW #115 stated that the care plan needed to be updated to reflect that the specified incontinence products that resident #009 required.

During an interview with the RAI Coordinator, they stated that they believed that resident #009 used a specified incontinence product during the day and at night and that this was a recent change. The RAI Coordinator verified that resident #009's care plan indicated incorrect incontinence interventions.

During an interview with the DOC, they indicated that the home's expectation was that resident care plans be updated by the RPN with any changes in required incontinence products once the change had been trialed and was determined to be effective.

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm to the residents of the home. The scope of the issue was a level three, as it related to three out of three residents reviewed. The home had a level two compliance history, as they had previous unrelated non-compliance in the last 36 months. (681)

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 01, 2018

## 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  17th  day of September, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

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

**Name of Inspector / Nom de l'inspecteur :** Stephanie Doni

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