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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 8, 2014	2014_281542_0010	S-000133-14	Resident Quality Inspection

Licensee/Titulaire de permis

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

BLIND RIVER DISTRICT HEALTH CENTRE - 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

JENNIFER LAURICELLA (542), JANET MCNABB (579)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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

This inspection was conducted on the following date(s): April 7, 8, 9, 10, 11, 14, 15, 16, 17, 2014

This inspection addresses both the Blind River District Health Centre, Long-Term Care Unit, Home # 2865 and ELDCAP Unit, Home #2795.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Long-Term Care Nurse Manager(s), Manager of Environmental Services, Food Service Manager, Registered Staff, Behavioral Supports Ontario Nurse (BSO), Personal Support Workers (PSWs), President of the Family Council, Members of the Resident's Council, Family Members and Residents.

During the course of the inspection, the inspector(s) made direct observations of the delivery of care and services to residents, conducted a daily walk-through of the home, reviewed resident health care records, reviewed policies and procedures, reviewed various home's programs, reviewed home's medication management system, quality improvement, infection prevention and control program and admission process.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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. On April 11, 2014 Inspector interviewed Personal Support Worker (PSW) # 107 and Long-Term Care (LTC) Nurse Manager # 101 and was informed that resident # 83236's pressure ulcer is now healed. Inspector reviewed resident's current care plan that is utilized by the direct care staff. Under the section Bed Mobility it stated that resident has a pressure ulcer. Inspector reviewed the care plan kardex that is also used by the direct care staff and it also indicated that resident has a pressure ulcer.

The Inspector reviewed resident # 83243's health record which contained an order from the Registered Dietitian (RD). The RD ordered several nutritional supplements for the resident. Inspector then reviewed resident # 83243's most current care plan and noted that it did not contain all of the ordered nutritional supplements. Inspector conducted an interview with registered staff # 106 and was informed that all of the nutritional supplements/orders are to be on the care plan. Registered staff # 106 also acknowledged that the dietary summary sheets located in the dining room were also missing all of the RD's orders for resident # 83243.

2. On April 15, 2014 Inspector reviewed resident # 83242's health care record and noted in the progress notes that resident had a specific urinary intervention conducted

to promote wound healing due to incontinence. Resident's current care plan accessible to direct care staff was also reviewed and it did not indicate the use of the specific urinary intervention. Registered staff # 109 informed Inspector that the use of the specific urinary intervention should be on resident's care plan but it is not up to date. [s. 6. (1) (c)]

3. On April 16, 2014 Inspector reviewed the most current care plan and supporting documents for resident # 83250 that are used by the direct care staff. The CCRS MDS Kardex and the care plan kardex reviewed by Inspector did not include the specific urinary interventions for resident # 83250. It was also noted by this Inspector that resident # 83250's specific urinary intervention was not carried to the April Medication Administration Sheet (MARS) from the March MARS. This was verified by registered staff # 109 as being missed. [s. 6. (1) (c)]

4. Over the course of this inspection, Inspectors reviewed care plans for multiple residents and noted that in several instances residents' care plans had different residents care plans listed on the reverse side. For example, resident # 83251's care plan had 3 different residents included in their care plan on the reverse pages. Inspector asked registered staff # 106 about this and they stated that this is done to save paper.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care, specifically to residents # 83236, # 83250, # 83251, # 83242 and # 83243. [s. 6. (1) (c)]

5. Inspector reviewed resident # 83250's current care plan which indicated that the staff were to monitor intake and urinary output every shift. The flow sheet records were reviewed by the Inspector and they did not include any outputs recorded nor was there a form to record output for this resident. Registered staff # 109 informed inspector that the staff do not monitor the intake and urinary output but the PSW's watch for any concerns.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan pertaining to resident # 83250. [s. 6. (7)]

6. The Inspector reviewed resident # 83242's health care record and noted that this resident has a pressure ulcer, this was also confirmed with staff interviews. The health care record indicated that the Registered Dietitian had conducted an

assessment and ordered several nutritional supplements. Upon further review of resident's health care record it was noted that the care plan accessible to the direct care staff was not up to date and did not contain any of nutritional supplement orders from the RD and no mention of the resident's pressure ulcer.

The licensee has failed to ensure that resident # 83242 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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. On April 11, 2014 Inspector interviewed Long-term Care (LTC) Nurse Manager # 101 and was informed that the home does not have a skin and wound care program. The LTC Nurse Manager informed this Inspector that she still needed to develop the program. Inspector also interviewed another LTC Nurse Manager # 100 who also acknowledged that the home does not have a skin and wound care program.

The licensee has failed to ensure that a skin and wound care program is developed and implemented in the home that: promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions. [s. 48. (1) 2.]

2. On April 15, 2014 Inspector interviewed LTC Nurse Manager # 100 and was informed that the home does not currently have a continence care and bowel management program and the home does not currently use any kind of incontinence assessments. On April 15, 2014, Registered staff # 106 also informed this Inspector that the home does not currently have a continence care and bowel management program nor does not the home have or use any kind of assessments related to this program.
Inspector interviewed registered staff # 109 and was informed that the home does not have any policy or procedure for continence or bladder training and that they just follow what is specific on the care plan for each resident. Furthermore, registered staff # 109 also stated that the PSW's empty the catheter bags but do not necessarily measure the amount of drainage but rather just alert the registered staff that the amount seems "good enough."

The licensee has failed to ensure that an interdisciplinary continence care and bowel program is developed and implemented in the home that promotes continence and ensure that resident's are clean, dry and comfortable. [s. 48. (1) 3.]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. On April 10, 2014 Inspector observed resident # 83236 to have 2 full bed rails raised on their bed. Health care record was reviewed for this resident which indicated on their current care plan under the section Restraint: when resident is resting in bed put both full rails up. Registered staff # 106 informed Inspector on April 14, 2014 that they did not believe that anyone assessed resident's bed system in accordance with evidence-based practices, and explained that Inspector should speak with the Manager of Environmental Services as they would have more details. On April 14, 2014 Manager of Environmental Services was interviewed by this Inspector and was informed that none of the residents bed systems have been evaluated at the home.

The licensee failed to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (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 where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence - based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. On April 11, 2014 inspector reviewed resident # 83236's current care plan which identified under the Restraint section that the resident was to have both full side rails up when resting in bed. Health care record was reviewed, there was no mention that any alternatives to restraining were considered and tried. Inspector reviewed two Restraint Alternative Checklists under PointClickCare, both assessments did not indicate whether any alternatives were used. On April 15, 2014 Inspector interviewed Personal Support Worker (PSW) # 111 in which they stated that no other alternatives have been used to their knowledge. Inspector also interviewed PSW # 112 and was informed that no other alternatives to the bed rails have been used for this resident.

The licensee failed to ensure the resident # 83236's plan of care included alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk. [s. 31. (2) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the restraining of a resident by a physical device may be included in a resident's plan of care only if alternatives to restraining resident # 83236 have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk, to be implemented voluntarily.

WN #5: 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. On April 11, 2014 Inspector reviewed resident # 83243's health care record and was unable to locate weekly wound assessments/reassessments for this resident. Most recent quarterly review assessment indicated that this resident had a pressure ulcer.
On April 11, 2014 Inspector spoke with the LTC Nurse Manager # 101 and was informed that she completes the majority of the weekly wound assessments however they are not always documented. The LTC Manager # 101 also informed this Inspector the weekly wound assessments are completed on PointClickCare or on the paper copy of the Wound Record when they are completed. Inspector reviewed the home's policy titled Pressure Ulcer Management which indicated that a resident with a pressure ulcer is to have the ulcer re-assessed weekly with the following documented: stage, location, size, odour, condition of skin at base and at edges of open area, sinus tracts, exudates.
The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, specifically related to resident # 83243. [s. 50. (2) (b) (iv)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. On April 10, 2014 Inspector spoke with LTC Nurse Manager # 101 and was informed that the Residents' Council and Family Council act jointly and meet monthly. The members of the joint council are not separated and have several family as well as staff representatives joining the meetings. A Residents' Council that shall be attended by residents only does not currently exist in the home.
On April 10, 2014 Inspector also interviewed resident # 83282 who is a member of the Residents' Council for the past year. When asked who is the President of the Residents' Council, resident # 83282 stated it was a family member. Inspector reviewed the most recent Residents' Council minutes and noted that out of the 10 attendees only 2 were residents of the long-term care home.

The licensee has failed to ensure that only residents of the long-term care home are members of the Residents' Council. [s. 56. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Upon review of the resident's health care records during stage one of the inspection it was noted by this Inspector that the residents only had an admission height documented in PointClickCare (PCC). Registered staff # 106 stated that all of the heights and weights are documented on PCC. Inspector asked staff # 106 if annual heights are done. Staff # 106 stated that they were completed but they were not documented. On April 17, 2014 Inspector 542 and 579 met with the Food Service Manager and were informed that they were unsure if the home completed annual heights or not and that they just used whatever date was available to complete their work.

The licensee failed to ensure that with respect to each resident, a height is recorded annually. [s. 68. (2) (e) (ii)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. Inspector conducted interviews with registered staff # 109 and Personal Support Worker (PSW) # 110 on two separate dates and was informed that the home does not offer a beverage in the morning. Resident # 83252 and # 83221 were interviewed by Inspectors and both said they are not offered a between-meal beverage in the morning. Inspector reviewed the PSW flow sheet and noted that it contained columns to record between-meal beverages that are offered in the afternoon and evening however there is no mention of the morning beverage on the flow sheet.

The licensee has failed to ensure that residents are offered a minimum of, a between meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. Inspectors interviewed the CEO and were informed that the posting of the measures to be taken in case of fire are posted in the nursing station for the staff but they are not posted for the residents in a conspicuous and easily accessible location.

The licensee failed to ensure that the required information is posted in the home, specifically pertaining to an explanation of the measures to be taken in case of fire, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. [s. 79. (3) (i)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Inspector interviewed LTC Nurse Manager # 100 and asked if there was a process to report and locate residents' lost clothing and personal items. LTC Nurse Manager stated that they did not have a process in place, but most staff would just go and report it to PSW # 107 and they would deal with the missing item.
Inspector also interviewed Manager of Environmental Services and was informed that the home does not have a formal process in place to report and locate residents' missing items.

The licensee has failed to ensure that there is a process to report and locate residents' lost clothing and personal items. [s. 89. (1) (a) (iv)]

Issued on this 20th day of May, 2014

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JENNIFER LAURICELLA (542), JANET MCNABB (579)
Inspection No. / No de l'inspection :	2014_281542_0010
Log No. / Registre no:	S-000133-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 8, 2014
Licensee / Titulaire de permis :	BLIND RIVER DISTRICT HEALTH CENTRE 525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0
LTC Home / Foyer de SLD :	BLIND RIVER DISTRICT HEALTH CENTRE - LTC UNIT 525 CAUSLEY STREET, P. O. BOX 970, BLIND RIVER, ON, P0R-1B0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	GASTON LAVIGNE

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

To BLIND RIVER DISTRICT HEALTH CENTRE, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall comply with LTCHA, 2007 S.O.2007, c.8, s. 6. (1) (c) to ensure there is a written plan of care for each resident, specifically related to residents # 83236, # 83250, # 83251, # 83242, and # 83243, that sets out clear directions to staff and others who provide direct care to the resident.

Grounds / Motifs :

1. Two previous written notifications have been issued under LTCHA s.6 (1) (c). Including two Voluntary Plan of Correction (VPC) issued in July 2012 during inspection # 2012_140158_0007 and in March, 2013 during inspection # 2013_139163_0007.

On April 11, 2014 Inspector interviewed Personal Support Worker (PSW) # 107 and Long-Term Care (LTC) Nurse Manager # 101 and was informed that resident # 83236's pressure ulcer is now healed. Inspector reviewed resident's current care plan that is utilized by the direct care staff. Under the section Bed Mobility it stated that resident has a pressure ulcer. Inspector reviewed the care plan kardex that is also used by the direct care staff and it also indicated that resident has a pressure ulcer.

The Inspector reviewed resident # 83243's health record which contained an order from the Registered Dietitian (RD). The RD ordered several nutritional supplements for the resident. Inspector then reviewed resident # 83243's most current care plan and noted that it did not contain all of the ordered nutritional

supplements. Inspector conducted an interview with registered staff # 106 and was informed that all of the nutritional supplements/orders are to be on the care plan. Registered staff # 106 also acknowledged that the dietary summary sheets located in the dining room were also missing all of the RD's orders for resident # 83243. (542)

2. On April 15, 2014 Inspector reviewed resident # 83242's health care record and noted in the progress notes that resident had a specific urinary intervention conducted to promote wound healing due to incontinence. Resident's current care plan accessible to direct care staff was also reviewed and it did not indicate the use of the specific urinary intervention. Registered staff # 109 informed Inspector that the use of the specific urinary intervention should be on resident's care plan but it is not up to date.

On April 16, 2014 Inspector reviewed the most current care plan and supporting documents for resident # 83250 that are used by the direct care staff. The CCRS MDS Kardex and the care plan kardex reviewed by Inspector did not include the specific urinary interventions for resident # 83250. It was also noted by this Inspector that resident # 83250's specific urinary intervention was not carried to the April Medication Administration Sheet (MARS) from the March MARS. This was verified by registered staff # 109 as being missed.

Over the course of this inspection, Inspectors reviewed care plans for multiple residents and noted that in several instances residents' care plans had different residents care plans listed on the reverse side. For example, resident # 83251's care plan had 3 different residents included in their care plan on the reverse pages. Inspector asked registered staff # 106 about this and they stated that this is done to save paper.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care, specifically to residents # 83236, # 83250, # 83251, # 83242 and # 83243. (579)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

Order # / Ordre no : 002

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

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 shall comply with O. Reg. 79/10, s. 48 (1) 2, 3 and prepare, submit and implement a plan for developing and implementing a skin and wound care program and a continence care and bowel management program. The plan shall include specified time frames for the development and implementation and identify the staff member (s) responsible for implementation. Further, the written description of the program, shall include goals and objectives, relevant policies, procedures and protocols and a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment and incontinence.

This plan shall be submitted in writing to Jennifer Lauricella, Long Term Care Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5, or Fax at 705 564-3133. This plan must be submitted by June 13th, 2014 and fully implemented by July 30, 2014

Grounds / Motifs :

1. One previous Written Notification (WN) of non-compliance associated with the same legislated requirement as s. 48 (1) was issued under LTCHA s. 30 (1) in January 2013 during inspection # 2012_099188_0048, along with a compliance order. The compliance order was complied in December 2013 during inspection # 2013_139163_0040.

On April 11, 2014 Inspector interviewed Long-term Care (LTC) Nurse Manager # 101 and was informed that the home does not have a skin and wound care program. The LTC Nurse Manager informed this Inspector that she still needed to develop the program. Inspector also interviewed another LTC Nurse Manager # 100 who also acknowledged that the home does not have a skin and wound care program.

The licensee has failed to ensure that a skin and wound care program is developed and implemented in the home that: promotes skin integrity, prevents the development of wounds and pressure ulcers, and provides effective skin and wound care interventions. (542)

2. On April 15, 2014 Inspector interviewed LTC Nurse Manager # 100 and was informed that the home does not currently have a continence care and bowel management program and the home does not currently use any kind of incontinence assessments. On April 15, 2014, Registered staff # 106 also informed this Inspector that the home does not currently have a continence care and bowel management program nor does not the home have or use any kind of assessments related to this program.
Inspector interviewed registered staff # 109 and was informed that the home does not have any policy or procedure for continence or bladder training and that they just follow what is specific on the care plan for each resident. Furthermore, registered staff # 109 also stated that the PSW's empty the catheter bags but do not necessarily measure the amount of drainage but rather just alert the registered staff that the amount seems "good enough."

The licensee has failed to ensure that an interdisciplinary continence care and bowel program is developed and implemented in the home that promotes continence and ensure that resident's are clean, dry and comfortable. (579)

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 : Jul 30, 2014

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

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
Performance Improvement and Compliance 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
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
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
Direction de l'amélioration de la performance et de la conformité
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 8th day of May, 2014

Signature of Inspector /
Signature de l'inspecteur :

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

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