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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 4, 2015	2014_376594_0019	S-000429-14	Resident Quality Inspection

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST
400 Olive St. NORTH BAY ON P1B 6J4

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

CASSELLHOLME
400 OLIVE STREET NORTH BAY ON P1B 6J4

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

MONIKA GRAY (594), LINDSAY DYRDA (575), VALA MONESTIMEBELTER (580)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 06-10, 2014 and October 14 - 17, 2014

This inspection includes Log #S-000218-14, S-000276-14, S-000378-14, S-000207-14, S-000204-14,and S-000220-14.

During the course of the inspection, the inspector(s) spoke with Residents, Unit Clerk, Dietary Aide, Food Service Worker, Housekeeping staff, Laundry staff, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Dietitian, Registered Nurses (RNs), Registered Nurse Supervisors, Food and Nutrition Supervisor, Occupational Health & Wellness Coordinator, Human Resources Assistant, Administrative Nursing Assistant, Manager of Activities, Nutrition and Food Services Manager, Purchasing and Inventory Manager, Manager of Activities, Manager of Infection Control and Documentation, Manager of Housekeeping and Laundry, Manager of Clinical Standards, Director of Human Resources, Director of Clinical Services, and the Interim Chief Executive Officer.

The inspector(s) also reviewed Policies, Plans of Care and other documentation within the home, conducted daily walk through of the resident care areas and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **8 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to protect residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff. The licensee was issued a

compliance order related to the Long Term Care Homes Act s.19 in inspection 2014_283544_0011 to be complied with by May 16, 2014. The order was to ensure residents are protected from abuse and neglect by all staff, in particular staff #S-200 and that its Human Resource practices support compliance with the duty to protect.

During the Resident Quality Inspection, inspector #594 reviewed the personnel file of staff #S-200 and noted a letter to the Director of the Ministry of Health and Long-Term Care stating when staff #S-200 is returned to their duties, and during the six week training period, every precaution will be taken to supervise their interactions with residents and have regular feedback with the employee. A memorandum to staff #S-200 in 2014 stated that staff #S-200 was expected to complete a minimum of eight weekly counselling sessions at an outside agency, each session one hour in length, by no later than two months from the time of the letter.

Inspector #594 interviewed staff #S-302 who stated that staff #S-200 completed seven counselling sessions. Inspector #594 reviewed documentation by staff #S-302 on feedback from the outside agency working with staff #S-200 and from the supervisor and noted the following documented:
- that staff #S-200 contacted counselling centre.
- the counsellor assigned to staff #S-200 was on vacation.
- staff #S-302 contacted unit staff about staff #S-200. Unit staff stated "do not see staff #S-200 very often".
- a message from the counsellor, that staff #S-200 missed an appointment and a letter was sent for another appointment which was also missed.
- Dates of sessions attended by staff #S-200.

By the two month time deadline as outlined in the memorandum to staff #S-200, staff #S-200 had attended only six sessions, a seventh session was attended after the deadline, leaving one counselling session outstanding. Upon review of staff #S-200's personnel file, Inspector #594 located a performance review prepared in 2014 stating that staff #S-200 was generally kind, negative interaction with residents on occasion. Interview with staff #224, who prepared the performance review for staff #S-200, clarified that the statement generally kind and polite was input from other staff including peers. The statement negative interactions was relating to verbal incidents issued in a compliance order in inspection 2014_283544_0011. The inspector further located an attached memo from staff #S-302 suggesting removing the statement about being kind and to replace with the statement that staff #S-200 has had inappropriate verbal communication with two residents in the past year and staff #S-200 is participating in a

program to improve in this area.

In an interview with Inspector #594, staff #S-305 told the inspector that the updated Human Resource progressive discipline policy was currently in draft and still pending approval by the interim Chief Executive Officer. [s. 19. (1)](594)

2. During the Resident Quality Inspection, resident #5096 told Inspector #575, that approximately one month ago around 0400 hrs the resident had to urinate however, the resident's roommate was using the shared bathroom. The resident stated that instead of urinating in the bed or on the floor they used their garbage can. Subsequently, the resident stated that staff #S-210 came into the resident's room and yelled at the resident stating that resident #5096 should have waited and should not have done that. The resident told the inspector that they did not report the incident because the staff member later apologized. The inspector reviewed a progress note in resident #5096's health care record completed by staff #S-210 that indicated that the staff member 'told resident they couldn't keep urinating in their garbage bin due to safety issues and the reason they have not been given a commode is because they are used for residents who are on isolation'; and that the resident stated they were 'going to report me'.

On October 15, 2014 inspector #575 notified staff #S-302 regarding the incident of alleged verbal abuse toward resident #5096 by staff #S-210. The home initiated an investigation immediately, however on October 17, 2014 #S-301 told the inspector that the staff member was still scheduled in the same home area of resident #5096 and was still looking after the resident. The inspector asked staff #S-301 how the home was ensuring that the resident was protected from abuse if the staff member was still scheduled and the investigation was pending. Staff #S-301 was unable to provide a response. Approximately one hour later during the exit meeting on October 17, 2014, staff #S-301 told the inspector that the home now has left a phone message with staff #S-210 to advise of a scheduled meeting the same day to notify that they will be off work until the investigation is complete. Staff #S-301 also stated that the meeting is scheduled but they have not heard from the staff member yet.
The licensee has failed to ensure that resident #5096 was protected from abuse by staff #S-210. [s. 19. (1)](575)

3. On October 15, 2014 during the Resident Quality Inspection, resident #4998 told Inspector #580 that staff #S-211 "turns me hard, it hurts a bit, does it every time, and that they looked after me last week." The inspector reviewed the Point of Care flow sheet for

resident #4998 which indicated that staff #S-211 had provided care including transferring, dressing, turning and repositioning to the resident during six shifts in 15 days. Inspector #580 reviewed resident #4998's interdisciplinary conference notes of 2014 which indicated the family of resident #4998 stated that staff #S-211 is rough during baths and that staff #S-209 is to follow up with staff #S-211.

Inspector #580 reviewed the Home's Complaint Documentation Form, which documents:
-that staff #S-209 (the staff assigned to the Home's 'investigation' into the family's 'complaint') discussed the complaint with resident #4998 who confirmed that staff #S-211 was "rough" with them; and when asked if anyone else was rough with them, resident #4998 replied that only staff #S-211 was and it was when being rolled and turned to be positioned to transfer;
-that in a telephone conversation with staff #S-211, the investigating staff informed staff #S-211 of the complaint; then called a second time to discuss resolution, during which time staff #S-211 confirmed that resident #4998 complained of pain at times when being transferred; the investigating staff documents that they "instructed staff #S-211 to be more gentle and slow down pace".
-that the investigating RN documented that they spoke with resident #4998 and informed them to be more vocal if uncomfortable at any time during care, and confirms both agreed
-that the Home's Complaint Documentation Form was reviewed by staff #S-302.
-that the Home's Complaint Documentation Form was reviewed by the Chief Executive Officer.

Staff #S-302 confirmed the following to Inspector #580:
1. that resident #4998's family member advised the Home that their family member, resident #4998, had a formal complaint about staff #S-211, who looked after them and was rough with them and caused pain,
2. that the Home had the staff investigate and deal with the complaint,
3. that staff #S-302 did not believe the complaint warranted reporting to the Ministry,
4. that it was normal to investigate, and depending on the circumstance, to give counselling, which was done in this case, or continue to progressive discipline depending on severity.

On October 15, 2014 resident #4998 told Inspector #580 that the rough handling by staff #S-211 had continued the past week. Inspector #580 reported to staff #S-303, #304 and #302 that resident #4998 continues to complain of rough handling by staff #S-211 when they are turned and rolled. [s. 19. (1)](580)

Given the lack of follow up and lack of implementation of the home's plan for staff #S-200, the draft human resource policy, the two cases of abuse brought forward to the licensee by the Inspectors during the Resident Quality Inspection, a history of non-compliance related to protecting residents from abuse and promoting their right to be protected from abuse during 2011 and 2014 and a documented pattern of inaction on the part of the licensee, the licensee has failed to ensure residents are protected from abuse and neglect by all staff. [s. 19. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. Inspector #580 reviewed the home's Employee Orientation Checklist (undated) which states staff are to read and understand the home's policy on Resident Rights and Resident Freedom from Abuse. The inspector reviewed the Home's Residents' Rights: Prevention of Abuse and Neglect policy #R7.1.0 dated September 12, 2013 which identifies definitions of abuse and neglect, communication of the policy, education on the Bill of Rights, auditing, discipline, training requirements which include behaviour in-service, Resident Rights, Gentle Persuasive Approach (GPA), and a conflict resolution workshop. The policy does not include Zero tolerance of abuse and neglect of residents, mandatory reporting or Whistle-blower protection.

During an interview with the inspector, staff #S-202 stated that they had no idea of any Ministry phone number to call to report abuse, did not know the term Zero Tolerance, and when asked by the inspector what training in the abuse policy they had received, replied "not that I'll remember but I think there are monthly papers, but don't forget I was on nights for four years";
-Staff #S-26 told the Inspector that they don't remember training on abuse policies.

On October 16, 2014 staff #S-303 told Inspector #580 that staff #S-301 stated that the Home does not provide staff training on mandatory and immediate reporting of abuse. [s. 76. (2) 3.]

2. The licensee failed to ensure that staff receive training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities. Inspector #580 reviewed the home's Employee Orientation Checklist (undated) which states staff are to read and understand the home's various policies but fails to identify Whistle-Blowing Protection. The inspector reviewed the home's Whistle-Blowing Protection: Staff Reporting policy #W6.0 dated June 21, 2011 which states staff members will receive orientation and annual re-training on the reporting obligations under the LTCHA, the home's internal procedures for reporting, and the whistle-blowing protections in the LTCHA.

During an interview with the inspector, staff #S-217 stated they did not know about whistle-blowing protection; staff #S-215 stated they did not know the name of whistle-blowing protection but knew that there would be protection from their union if they got in trouble for reporting; staff #S-202 stated they had no idea that there was protection for the person reporting abuse; and staff #S-216 stated they remember attending an in-service seven months ago on harassment but does not remember training on whistle-blowing protection or abuse policies.

On October 16, 2014 staff #S-303 told Inspector #580 that staff #S-301 stated that the home does not provide staff training on whistle-blowing protections. [s. 76. (2) 5.]

3. The licensee failed to ensure that all staff have received retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections. Inspector #580 reviewed the home's Residents' Rights: Prevention of Abuse and Neglect policy R7.1.0 dated September 12, 2013 and the

Whistle-Blowing Protection: Staff Reporting policy W6.0 dated June 21, 2011 which both state staff members will receive annual re-training on the reporting obligations under the LTCHA, the home's internal procedures for reporting, and the whistle-blowing protections in the LTCHA.

The inspector reviewed staff #S-211's training records which indicated attendance for training in GPA and training on two of the twenty-seven Residents' Bill of Rights. The Inspector was not able to locate any training records for the home's policy to promote zero tolerance of abuse and neglect of residents, and no training records for the duty to make mandatory reports under section 24 nor training for the whistle-blowing protection.

During and interview with the inspector, staff #S-217 stated they had taken GPA training but probably not within the last year and had no abuse training in 2014; staff #S-215 stated when asked if they had received training on the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 or training for the whistle-blowing protection replied "not that I'll remember but I think there are monthly papers". Staff #S-216 stated they do not remember training on Whistle-blowing protection or abuse policies.

On October 16, 2014 staff #S-303 told Inspector #580 that staff #S-301 stated the home does not provide staff training on mandatory and immediate reporting of abuse and whistle-blowing protections. [s. 76. (4)]

4. The licensee has failed to ensure that training has been provided for all staff in infection prevention and control. Review of 2013 training and retraining for staff in infection prevention and control identified 280/335 or 84% of staff employed at the home received annual training. Inspector #594 interviewed #S-302 who confirmed the infection prevention and control education attendance. Given only 280 of 335 staff completed training on infection prevention and control, the licensee failed to ensure all staff received training annually. [s. 76. (4)]

Additional Required Actions:

CO # - 002, 003, 006 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. The licensee has failed to ensure where bed rails are used, the resident has been assessed and their bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. Inspector #594 reviewed resident #4998, #5063 and #5099 health care record's and was unable to locate a bed rail assessment. Inspector #594 interviewed staff #S-213 who stated that registered nurses assess residents for bed rails. Staff #S-202 told the inspector that registered nurses collaborate with family, resident and PSWs to assess residents for bed rails. Inspector #594 interviewed management staff #S-303 who stated no assessment for bed rails are completed. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management. Inspector #575 asked the home to provide the number of direct care staff who have completed training in falls prevention and management for 2013 and 2014. Staff #S-303 reviewed the home's training records to determine the number of direct care staff who have completed training in falls prevention and management. In 2013 only 101 of 159 staff had completed the annual training and in 2014 only 12 of 159 staff had completed the annual training. The staff member told the inspector that in 2013 the training was in April, therefore the inspector noted that the 2014 training should have been completed in April. [s. 221. (1) 1.]

2. The licensee has failed to ensure training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device. Review of the February 2013 Education on Restraints attendance identified 18 of 159 direct care staff, 11%, received training with only registered staff attending and no attendance by unregulated health care providers. Review of the 2014 Education on Restraints attendance numbers provided by staff #S-303 identified only 12 of 165 employees, 7%, received training. Inspector #594 interviewed staff #S-303 who confirmed the restraint education attendance. [s. 221. (1) 5.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and that the policy is complied with. Inspector #594 observed resident #5063 with two full padded side rails in use on October 07, 2014 and resident #4998 with two full side rails in use on October 09, 2014. Staff #S-213 told the inspector that both residents are physically unable to get out of bed and the bed rails are used for safety so they do not fall out of bed. Staff #214 told the inspector that bed rails are used for both residents so they do not fall out of bed and that both residents are physically unable to release the bed rail or have the mobility to get out of bed.

Inspector #594 reviewed the care plans for residents #5063 and #4998. The care plan for resident #5063 stated Bed rails: Two full rails up at all times. Bed rail covers x2. The care plan for resident #4998 stated Bed rails: x2 rails.

Inspector #594 reviewed the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 which stated: The use of a physical device, from which a resident is able to both physically and cognitively release themselves, is not a restraining device. The definition of a physical restraint is any manual method, or any physical or mechanical device, material or equipment that is attached or adjacent to the resident's body, that the resident cannot remove and that restricts the resident's freedom of movement or normal access to his or her body. Devices not defined as restraints and don't require doctor's order include but not limited to partial bed rails.

In an interview with the inspector, staff #S-303 and #302 stated that the restraint policy does not clearly address bed rails as restraints in the home.

During the Resident Quality Inspection, Inspector #575 observed resident #5100 sleeping in a wheelchair with a restraint applied with no current order as told to the inspector by staff #S-219. Review of the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 states staff are to apply restraint as ordered and document reaction. Inspector #575 also reviewed resident #5103's health care record and noted the resident was ordered a restraint while in wheelchair and to document when restraint is used and monitor, every hour. Staff #S-221 opened the resident record on Point Click Care and told the inspector that the documentation of the monitoring of restraints was only required every shift according to Point of Care. Review of the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 states registered staff are to update Care Plan to identify type of restraint and use, and activate the documentation for unregistered staff in Point of Care.

Given the following: 1. that a physical device was applied to resident #5100, that had not been ordered or approved by a physician or a registered nurse in the extended class; 2. that all assessments, reassessments and monitoring, including resident #5103's response to the restraint failed to be documented every hour and, 3. that the home's restraint policy failed to identify all types of physical devices permitted to be used in the home, the licensee has failed to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and that the policy is complied with. [s. 29.]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 immediately report to the Director where there are reasonable grounds to suspect abuse of a resident. Inspector #594 reviewed a Complaint Documentation Form and Interdisciplinary Conference notes where a family member of resident #4998 brought forward, in an interdisciplinary conference, a concern that staff #S-211 was rough with resident #4998 during the resident's bath and when being rolled and turned and positioned for transfer. The licensee failed to recognize this as alleged abuse being brought forward, for which the licensee is required to report immediately to the Director. This report to the Director is not contingent upon the licensee completing its investigation or validating the allegation. A documented pattern of inaction regarding reporting certain matters to the Director on the part of the licensee is evidenced by non-compliance issued during inspections in 2011, 2012 and 2013. [s. 24. (1)]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: 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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 care set out in the plan of care was provided to the resident as specified in the plan. During the Resident Quality Inspection, inspector #575 observed resident #5100 sitting in a common room, hunched over, sleeping in a wheelchair with a restraint applied, wearing only socks on their feet. The inspector interviewed staff #S-218 who told the inspector that the resident was having a bad day and was being aggressive. The staff member told the inspector that they have an order for a restraint as needed when the resident is aggressive and that the resident normally wears shoes but the staff were unable to apply them this morning.

The inspector reviewed the resident's health care record and noted an restraint order PRN (as needed) only for 'aggression' and the consent form signed by the resident's Power of Attorney. The inspector also noted that in the resident's care plan it stated that the resident is to wear proper non-slip footwear. The inspector did not find an order for the restraint resident #5100 was observed with.

The inspector interviewed staff #S-219 if the resident had a restraint order. The staff member told the inspector that there was no current order and that the staff applied this restraint because the restraint that was ordered was unavailable. [s. 6. (7)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. Inspector #580 reviewed resident #5003's care plan on October 16, 2014 which identified respiratory interventions related to upper respiratory infection, fever and decreased oxygen saturation. One of the interventions was to monitor resident #5003's oxygen saturation every shift for two days or until therapeutic. A progress note of 2014 indicated that the resident was placed on tracking and isolation to monitor for further symptoms.

In an interview with the Inspector, resident #5003 told the inspector that they did have a cold a few weeks ago. Staff #S-208 told to the inspector they remember resident #5003 had a runny nose and a cough and was on isolation. Staff #S-209, who was in charge of the home area told the inspector that resident #5003 was added to the Outbreak List and placed on isolation and that there were no records showing resident #5003's vitals being checked and no record of action taken regarding intervention to monitor oxygen saturation every shift for two days or until therapeutic as per resident #5003's care plan.

Staff #303 and #301 confirmed to Inspector #580 that they had no records, no emails or other information about the resident's health status, illness symptoms or oxygen saturation levels. [s. 6. (7)]

3. The licensee has failed to ensure that the outcomes of the care set out in the plan of care are documented. Inspector #580 reviewed resident #5003's care plan on October 16, 2014 which indicated respiratory interventions related to an upper respiratory infection, fever and decreased oxygen saturation. One of the interventions was to monitor oxygen saturation every shift for two days or until therapeutic. A progress note of 2014 indicated that the resident was placed on tracking and isolation to monitor for further symptoms.

Resident #5003 told the inspector on October 17, 2014 that they did have a cold a few weeks ago. Staff #S-208 told to Inspector #580 that they remember resident #5003 had a runny nose and a cough and was on isolation but did not remember how long the isolation lasted.

Staff #S-209 who was in charge of the home area, told the inspector that resident #5003 was added to the Outbreak List and placed on isolation; that there was no record showing resident #5003's vitals being checked, no progress notes regarding resident #5003's health status, no record of action taken regarding intervention to monitor oxygen saturation every shift for two days or until therapeutic as per resident #5003's care plan;

that they had no idea who decided to remove resident #5003 from the outbreak list, no idea why there are no notes, has no plans to track the missing information, and had deleted their emails regarding information about resident #5003 illness symptoms and isolation on and around October 4, 2014.

On October 17, 2014 staff #303 and #301 told Inspector #580 that they had no records, no emails or other information about resident #5003's health status related to sore throat, runny nose, oxygen saturation levels, outbreak updates or removed from isolation. [s. 6. (9) 2.]

4. The licensee has failed to ensure that resident #5103 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. Inspector #575 reviewed resident #5103's health care record. The inspector noted that the resident sustained a fall in 2014 which resulted in a fracture. Upon return from hospital, a previous order for a restraint in wheelchair when fatigued as needed, was stopped and a new order for a 'restraint to be used only when in wheelchair' was ordered. The inspector reviewed the most recent medication review and the current medication administration record and determined that the current records reflected the previous order and did not reflect the new order made. Staff #S-216 confirmed to the inspector that the care plan had not been reviewed and revised to reflect resident #5103's current needs. [s. 6. (10) (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 resident #5103's plan of care is reviewed and revised when the resident's care needs change; resident #5003 and #5100's care is provided as set out in their care plans; and to ensure that the outcomes of the care set out in the plan are documented, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication response system can be easily seen, accessed and used by residents, staff and visitors at all times. During the course of the inspection, Inspectors #575, #580 and #594 observed random bundled call bell cords fastened at the wall outlet. Inspector #594 observed when privacy curtains were opened that some bundled call bell cords were not easily seen or accessible. Resident #001 told Inspector #594 when visiting with their co-resident, who has a bundled call bell cord, resident #001 will take along their call bell cord and cordless phone should they require any assistance. [s. 17. (1) (a)]

2. The licensee has failed to ensure that the resident-staff communication response system is on at all times. Inspector #594 tested the call bell at resident #5063 bedside which did not activate the call light or sound on October 10, 2014. Staff #S-207 confirmed that the call bell was not functioning. Inspector #594 tested the same call bell at resident #5063 bedside on October 16, 2014, which did not activate the call sound. [s. 17. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident -staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times and is on at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure implementation of policies and procedures relating to dietary services. Inspector #575 observed supper dining service in a dining area on October 14, 2014. The inspector observed staff #S-220 taking temperatures of the food before serving. The inspector asked the staff member where it was recorded and the staff member told the inspector that the temperature recording sheet was missing and

they were unable to document the temperatures. The inspector also noted that the staff member did not clean the temperature probe between uses. On October 15, 2014 the inspector asked staff #306 what the procedure was for taking temperatures. Staff #306 told the inspector that food temperatures are taken at the start of service and mid-service and the starting temperatures are recorded on the therapeutic spreadsheets. Staff #306 also stated to the inspector that the temperature probe should be cleaned between uses and staff have alcohol wipes to use.

The inspector reviewed the therapeutic spreadsheet for a week for one dining area and noted that hot temperatures were not recorded consistently and cold temperatures were not taken.

The inspector reviewed the home's policy titled 'Food Thermometers' last revised May 2014 and noted that the policy indicated, that when taking a series of temperatures at a meal, rinse probe with hot water and wipe with a clean paper towel, between each food sample OR wipe probe with alcohol swab between each sample and rinse with hot water. The inspector reviewed the home's policy titled 'Hot Holding' last revised May 2014 and noted that the policy indicated that staff are to check and record internal temperature of each food before serving. The inspector reviewed the home's policy titled 'Food Distribution' last revised May 2014 and noted that the policy indicated that the temperature of cold foods will be no greater than between 4 – 7 degrees Celsius at point of service.

Given staff are not consistently recording hot food temperatures, are not recording any cold food temperatures and not implementing proper procedures for cleaning temperature probe between uses, the licensee has failed to ensure that the home's policies titled 'Food Thermometers', 'Hot Holding', and 'Food Distribution' are implemented. [s. 68. (2) (a)]

2. 1. The licensee has failed to ensure that the home's policy titled 'Monitoring Resident's Weight & Height' was implemented. Inspector #575 reviewed the health care records for resident #5100, #5103, #5020, and #5063. The inspector noted that resident #5100's height was not taken in 2012, resident #5103 was only taken on admission in 2012, resident #5020's height was not taken in 2010, 2012, or 2013, and resident #5063's height was not taken in 2012.

The inspector interviewed staff #S-216 who confirmed to the inspector that residents' heights are to be taken on admission and annually and are to be recorded under height

in Point Click Care.

The Inspector reviewed the home's policy titled 'Monitoring Resident's Weight & Height' last revised May 2014. The policy indicated that each resident is to be weighed on admission, monthly thereafter, more frequently as requested by the Dietitian or physician, and whenever the resident returns to the facility/home after admission to hospital and each resident's height is to be taken on admission and annually thereafter. The policy further indicated that this information is to be recorded in Point Click Care.

2. The licensee has failed to ensure the development and implementation of policies and procedures relating to nutritional care. Inspector #575 reviewed the home's policy titled 'Weight Change Management' last revised May 2014 and determined that the policy did not include applicable requirements under the Act regarding O.Reg.79/10, s.69.(2) such that if a resident experiences a weight change of 7.5 per cent of body weight, or more, over three months the home shall ensure that residents are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated. [s. 68. (2) (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 residents' heights are taken annually; food temperatures are checked and recorded prior to food service; and the home's policy titled Monitoring Resident's Weight & Height is in compliance and implemented in accordance with all applicable requirements under this Act and its regulations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff only apply a physical device that has been ordered or approved by a physician or a registered nurse in the extended class. During the Resident Quality Inspection, inspector #575 observed resident #5100 sitting in a common room, hunched over, sleeping in a wheelchair with a restraint applied, wearing only socks on their feet. The inspector interviewed staff #S-218 who told the inspector that the resident was having a bad day and was being aggressive. The staff member told the inspector that they have an order for a restraint or wheelchair as needed when the resident is aggressive and that the resident normally wears shoes but the staff were unable to apply them this morning.

The inspector reviewed the resident's health care record and noted an order for a restraint PRN (as needed) only for 'aggression' and the consent form signed by the resident's Power of Attorney. The inspector did not find an order for a wheelchair with a restraint.

The inspector interviewed staff #S-219 to determine if the resident had an order for the restraint. The staff member told the inspector that there was no current order and that the staff applied this restraint because the restraint that was ordered was unavailable.

Inspector #594 reviewed the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 which states registered staff are to instruct non registered staff to

apply the restraint as ordered and non registered staff are to document the resident's reaction. [s. 110. (2) 1.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: All assessment, reassessment and monitoring, including the resident's response. Inspector #575 reviewed resident #5103's health care record. The inspector noted that the resident is ordered a restraint while in their wheelchair. The care plan identifies that staff are to monitor the resident every hour, confirm safety and comfort of resident, reposition every two hours, document when restraint is used and document restraint monitoring. Staff #S-221 told the inspector that restraint monitoring is completed on Point Click Care. The staff member opened the resident's record on Point Click Care and told the inspector that the documentation of the monitoring of restraints was only required every shift according to Point Click Care. Staff #S-216 confirmed to the inspector that Point Click Care was not set up properly to include the required documentation and thus the documentation was not completed.

Inspector #594 reviewed the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 which stated registered staff are to activate the documentation for the non registered staff in Point of Care which they failed to do. [s. 110. (7) 6.]

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 documentation of the monitoring of a physical device and that staff only apply a physical device that has been ordered or approved by a physician or a registered nurse in the extended class, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that written policies to provide for safe medication management are implemented. On October 9, 2014 staff #S-205 showed Inspector #580 a medication room where the inspector observed the home's supply of currently used medication. Amongst the current medication supply the inspector observed several expired medications and showed the following to staff #S-205:
-Aquacel Ag Dressing x 10 expired February, 2013
-Chemstrip x 100 expired 09/2014
-Chlorhexidine Gluconate Scrubs x 3 expired April, 2013

On October 9, 2014 Inspector #580 observed in another medication room and showed the following to staff #S-204:
-Bisacodyl 5mg 100 tablets expired September, 2014
-Soflax 100 mg 100 tablets expired August, 2014

Staff #S-201 told to the inspector that the night registered staff are to check the medication room for expired medication but was not aware of a checklist or a policy to check for expired medication.

The inspector reviewed the home's Handling of Medication Expiry and Dating of Medications policy #5-1 dated January 2014 which states to remove any expired medications from stock and order replacement if necessary. [s. 114. (3) (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 expired medications are removed from the regular supply of medications, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area or stored in a separate locked area within the locked medication cart. On October 9, 2014 staff #S-205 told Inspector #580 that the keys to the controlled substance drawer are kept by Registered Nurses and are also kept in an office, in a multiple key cupboard which is locked; that the key to the locked-multiple key cupboard is kept in an unlocked bottom drawer in the office, in the unlocked office and that the keys in the multiple key cupboard include the basement key and supply room key and are known and accessible by various staff in the building including maintenance staff, housekeeping staff and Personal Support Workers.

Staff #S-202 and #S-206 told Inspector #580 that any staff can access the multiple key cupboard in the office. Staff #S-203 stated to the inspector that the key unlocks the drawer for emergency supply controlled medication.

Inspector #580 observed the Home's Emergency Supply of controlled substances including Morphine, Hydromorph, Tylenol #3, and Diazepam in a single-locked stationary drawer in the locked medication room. The inspector observed the key for the emergency starter box drawer for controlled medication in a home area medication room which is kept in the multiple key cupboard in the office accessible by any staff member, including non-registered staff. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply including that access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. On October 10, 2014 Inspector #580 observed the stock drugs in a basement room with staff #S-207.

Staff #S-207 told the Inspector that stock medications are ordered, unpacked and kept in a basement room by staff #300, who does not dispense, prescribe or administer drugs in the home and is not the Administrator, and that staff #300 and Registered Nurses have the keys to the double locked room. Staff #S-203 told the inspector that Registered staff prepare a list of needed stock medication on Wednesdays, and give the list to staff #300 who brings the requested stock medication from the basement room to each home area medication room on Thursdays and gives it to the Registered staff.

The inspector reviewed the home's Medication Storage policy #3-4 which states all medications are to be safely stored and supervised in accordance with applicable legislation and the home's Storage of Monitored Medications policy #6-4 which states all monitored medications are to be safely stored to comply with legislative and home requirements. [s. 130. 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 steps are taken to ensure the security of the drug supply by restricting access to the areas to persons who may dispense, prescribe or administer drugs in the home and the Administrator, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. On October 6, 2014 during the initial walk through, Inspector #580 observed:
- uncovered linen carts outside seven rooms in a home area; three of the uncovered linen carts were adjacent to garbage bags with garbage in them; and two of the uncovered linen carts were located outside a room with contact precautions
- a used unlabelled hair brush in two home area tub rooms
- a pair of unlabelled dirty nail clippers on a table next to the tub and not in a container in one home area tub room

Staff #S-222 stated to the inspector that in one home area tub room there were dirty nail clippers on shelves in a container and clean nail clippers in a drawer and that night staff disinfect the dirty ones, but was not sure if the nail clippers in the container on the shelf had been disinfected. Staff #S-222 stated to the inspector that in that home area tub room it had an unlabelled, used deodorant which they then threw in the garbage.

On October 6, 2014 at 12:04 during the noon meal service in a home area dining room, Inspector #580 observed staff member clean a plate over the garbage, spill some food on the floor, clean the floor with paper napkins, return to the dining room and bring in three walkers for residents and kiss and give a close contact hug to a resident without any hand washing taking place. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food and fluids are prepared, stored, and served using methods which preserve taste, nutritive value, appearance and food quality. On October 6, 2014 inspector #594 observed two stacked bowls containing uncovered cereal stored in the upper cupboard of a home area dining room, during lunch service. On October 7, 2014 inspector #575 observed five stacked bowls containing uncovered cereal in the same cupboard, in the same home area dining area. Inspector #575 showed management staff #308 the bowls and the staff member told the inspector that storing the cereal in the bowls uncovered in the cupboard was not normal practice and that the cereal would be thrown out. [s. 72. (3) (a)]

WN #16: 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. The licensee failed to ensure that the most recent minutes of the Residents' Council meetings are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirements, if any, established by the regulations. On October 6, 2014 during the initial tour, Inspector #580 observed no Residents' Council minutes posted on the Residents' Council information board. Staff #309 confirmed to Inspector #580 that the minutes of the most recent Residents' Council meeting were not ready to be posted, that the Home keeps only one month's set of minutes posted and that they had removed the previous set of minutes. [s. 79. (3) (n)]

WN #17: 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. The licensee has failed to ensure that the processes to report and locate residents' lost clothing and personal items are developed and implemented. In three separate complaints submitted to the Director of the Ministry of Health and Long-Term Care in May, June and August, 2014 it was stated resident clothing goes missing. Inspector #594 interviewed staff #S-223 and staff #S-214 who stated that when resident clothing is lost, staff are to check in the resident room and in the laundry. Inspector #594 reviewed the home's Unmarked Resident Clothing/Lost Clothing policy #C-13 which stated that families are to report lost clothing to the nursing staff.

Nursing staff are to fill out a Resident Misplaced Clothing Form, which the nursing staff then submits to the Manager of Housekeeping and Laundry. Within 10 business days, (provided Manager is in the building) the Manager is to contact the POA (Power of Attorney). The Manager of Housekeeping will search for the items. A three month time line is given to see if items can be found according to the Unmarked Resident Clothing/Lost Clothing policy #C-13 and that information in regards to laundry services is also placed in the resident handbook.
Inspector #594 interviewed management staff #310 who stated there is no formalized process to report and locate resident's lost clothing and personal items and to communicate back to resident, family and staff. [s. 89. (1) (a) (iv)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision-maker, was notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of neglect of the resident, that causes distress to the resident that could potentially be detrimental to the resident's health or well-being. On October 17, 2014 Inspector #580 reviewed staff #S-211 personnel records which included a letter from staff #S-207, supervising RN with a copy to management staff #301 during which staff #S-211 was questioned regarding their neglect of resident #5003 on a day shift. The Inspector reviewed resident #5003's health care record and found no documentation regarding the incident of neglect nor documentation regarding the reporting of the neglect incident to the resident's substitute decision-maker. [s. 97. (1) (a)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The license has failed to ensure that the training and retraining for staff in infection prevention and control includes the use of personal protective equipment. Staff #302 told Inspector #594 that two videos are used in the training and retraining; Just Clean Your Hands and Chain of Transmission which address hand hygiene, modes of infection transmission as well as cleaning and disinfection practices. Staff #302 told Inspector #594 that retraining regarding personal protective equipment was limited to the application and removal of gloves.

Staff #302 told the inspector the home refers to Provincial Infectious Diseases Advisory Committee (PIDAC) documents when referring to infection prevention best practices. The inspector reviewed the PIDAC document titled Routine Practices and Additional Precautions. According to the document, it defines personal protective equipment as clothing or equipment worn for protection against hazards. Clothing or equipment includes but is not limited to gloves, gown, mask, respirators and eye protection. [s. 219. (4) (d)]

Issued on this 10th day of February, 2015

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MONIKA GRAY (594), LINDSAY DYRDA (575), VALA MONESTIMEBELTER (580)
Inspection No. / No de l'inspection :	2014_376594_0019
Log No. / Registre no:	S-000429-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 4, 2015
Licensee / Titulaire de permis :	BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST 400 Olive St., NORTH BAY, ON, P1B-6J4
LTC Home / Foyer de SLD :	CASSELLHOLME 400 OLIVE STREET, NORTH BAY, ON, P1B-6J4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jamie Lowery

To BOARD OF MANAGEMENT OF THE DISTRICT OF NIPISSING EAST, 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

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) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_283544_0011, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is requested to prepare, submit and implement a plan for achieving compliance under s. 19. (1) of the LTCHA. This plan is to include:
1. that staff #200 has completed all eight of their counselling sessions as identified in the home's plan;
2. that human resource practices in the home include but are not limited to investigation, reporting and actions to be taken which support compliance with the duty to protect;
3. that the home's progressive discipline policy is finalized and put into practise;
4. a plan to ensure that all staff receive training in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and that retraining occurs annually thereafter.

This plan is to be submitted to:
Monika Gray (594), Inspector - Nursing
Sudbury Service Area Office
Ministry of Health and Long-Term Care Performance Improvement and Compliance Branch
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
by Tuesday February 17, 2015

Grounds / Motifs :

1. 1. The licensee has failed to protect residents from abuse by anyone and to ensure that residents are not neglected by the licensee or staff. The licensee was issued a compliance order related to the Long Term Care Homes Act s.19

in inspection 2014_283544_0011 to be complied with by May 16, 2014. The order was to ensure residents are protected from abuse and neglect by all staff, in particular staff #S-200 and that its Human Resource practices support compliance with the duty to protect.

During the Resident Quality Inspection, inspector #594 reviewed the personnel file of staff #S-200 and noted a letter to the Director of the Ministry of Health and Long-Term Care stating when staff #S-200 is returned to their duties, and during the six week training period, every precaution will be taken to supervise their interactions with residents and have regular feedback with the employee. A memorandum to staff #S-200 in 2014 stated that staff #S-200 was expected to complete a minimum of eight weekly counselling sessions at an outside agency, each session one hour in length, by no later than two months from the time of the letter.

Inspector #594 interviewed staff #S-302 who stated that staff #S-200 completed seven counselling sessions. Inspector #594 reviewed documentation by staff #S-302 on feedback from the outside agency working with staff #S-200 and from the supervisor and noted the following documented:
- that staff #S-200 contacted counselling centre.
- the counsellor assigned to staff #S-200 was on vacation.
- staff #S-302 contacted unit staff about staff #S-200. Unit staff stated "do not see staff #S-200 very often".
- a message from the counsellor, that staff #S-200 missed an appointment and a letter was sent for another appointment which was also missed.
- Dates of sessions attended by staff #S-200.

By the two month time deadline as outlined in the memorandum to staff #S-200, staff #S-200 had attended only six sessions, a seventh session was attended after the deadline, leaving one counselling session outstanding. Upon review of staff #S-200's personnel file, Inspector #594 located a performance review prepared in 2014 stating that staff #S-200 was generally kind, negative interaction with residents on occasion. Interview with staff #224, who prepared the performance review for staff #S-200, clarified that the statement generally kind and polite was input from other staff including peers. The statement negative interactions was relating to verbal incidents issued in a compliance order in inspection 2014_283544_0011. The inspector further located an attached memo from staff #S-302 suggesting removing the statement about being kind and to replace with the statement that staff #S-200 has had

inappropriate verbal communication with two residents in the past year and staff #S-200 is participating in a program to improve in this area.

In an interview with Inspector #594, staff #S-305 told the inspector that the updated Human Resource progressive discipline policy was currently in draft and still pending approval by the interim Chief Executive Officer. [s. 19. (1)](594)

2. During the Resident Quality Inspection, resident #5096 told Inspector #575, that approximately one month ago around 0400 hrs the resident had to urinate however, the resident's roommate was using the shared bathroom. The resident stated that instead of urinating in the bed or on the floor they used their garbage can. Subsequently, the resident stated that staff #S-210 came into the resident's room and yelled at the resident stating that resident #5096 should have waited and should not have done that. The resident told the inspector that they did not report the incident because the staff member later apologized. The inspector reviewed a progress note in resident #5096's health care record completed by staff #S-210 that indicated that the staff member 'told resident they couldn't keep urinating in their garbage bin due to safety issues and the reason they have not been given a commode is because they are used for residents who are on isolation'; and that the resident stated they were 'going to report me'.

On October 15, 2014 inspector #575 notified staff #S-302 regarding the incident of alleged verbal abuse toward resident #5096 by staff #S-210. The home initiated an investigation immediately, however on October 17, 2014 #S-301 told the inspector that the staff member was still scheduled in the same home area of resident #5096 and was still looking after the resident. The inspector asked staff #S-301 how the home was ensuring that the resident was protected from abuse if the staff member was still scheduled and the investigation was pending. Staff #S-301 was unable to provide a response. Approximately one hour later during the exit meeting on October 17, 2014, staff #S-301 told the inspector that the home now has left a phone message with staff #S-210 to advise of a scheduled meeting the same day to notify that they will be off work until the investigation is complete. Staff #S-301 also stated that the meeting is scheduled but they have not heard from the staff member yet.
The licensee has failed to ensure that resident #5096 was protected from abuse by staff #S-210. [s. 19. (1)](575)

3. On October 15, 2014 during the Resident Quality Inspection, resident #4998 told Inspector #580 that staff #S-211 "turns me hard, it hurts a bit, does it every time, and that they looked after me last week." The inspector reviewed the Point of Care flow sheet for resident #4998 which indicated that staff #S-211 had provided care including transferring, dressing, turning and repositioning to the resident during six shifts in 15 days. Inspector #580 reviewed resident #4998's interdisciplinary conference notes of 2014 which indicated the family of resident #4998 stated that staff #S-211 is rough during baths and that staff #S-209 is to follow up with staff #S-211.

Inspector #580 reviewed the Home's Complaint Documentation Form, which documents:
-that staff #S-209 (the staff assigned to the Home's 'investigation' into the family's 'complaint') discussed the complaint with resident #4998 who confirmed that staff #S-211 was "rough" with them; and when asked if anyone else was rough with them, resident #4998 replied that only staff #S-211 was and it was when being rolled and turned to be positioned to transfer;
-that in a telephone conversation with staff #S-211, the investigating staff informed staff #S-211 of the complaint; then called a second time to discuss resolution, during which time staff #S-211 confirmed that resident #4998 complained of pain at times when being transferred; the investigating staff documents that they "instructed staff #S-211 to be more gentle and slow down pace".
-that the investigating RN documented that they spoke with resident #4998 and informed them to be more vocal if uncomfortable at any time during care, and confirms both agreed
-that the Home's Complaint Documentation Form was reviewed by staff #S-302.
-that the Home's Complaint Documentation Form was reviewed by the Chief Executive Officer.

Staff #S-302 confirmed the following to Inspector #580:
1. that resident #4998's family member advised the Home that their family member, resident #4998, had a formal complaint about staff #S-211, who looked after them and was rough with them and caused pain,
2. that the Home had the staff investigate and deal with the complaint,
3. that staff #S-302 did not believe the complaint warranted reporting to the Ministry,
4. that it was normal to investigate, and depending on the circumstance, to give counselling, which was done in this case, or continue to progressive discipline

depending on severity.

On October 15, 2014 resident #4998 told Inspector #580 that the rough handling by staff #S-211 had continued the past week. Inspector #580 reported to staff #S-303, #304 and #302 that resident #4998 continues to complain of rough handling by staff #S-211 when they are turned and rolled. [s. 19. (1)](580)

Given the lack of follow up and lack of implementation of the home's plan for staff #S-200, the draft human resource policy, the two cases of abuse brought forward to the licensee by the Inspectors during the Resident Quality Inspection, a history of non-compliance related to protecting residents from abuse and promoting their right to be protected from abuse during 2011 and 2014 and a documented pattern of inaction on the part of the licensee, the licensee has failed to ensure residents are protected from abuse and neglect by all staff. [s. 19. (1)] (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2015

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. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that no person performs their responsibilities before receiving training including but not limited to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

Grounds / Motifs :

1. The licensee failed to ensure that staff receive training on the home's policy to promote zero tolerance of abuse and neglect of residents, prior to performing their responsibilities. Inspector #580 reviewed the home's Employee Orientation Checklist (undated) which states staff are to read and understand the home's policy on Resident Rights and Resident Freedom from Abuse. The inspector reviewed the Home's Residents' Rights: Prevention of Abuse and Neglect policy #R7.1.0 dated September 12, 2013 which identifies definitions of abuse and neglect, communication of the policy, education on the Bill of Rights, auditing, discipline, training requirements which include behaviour in-service, Resident Rights, Gentle Persuasive Approach (GPA), and a conflict resolution workshop. The policy does not include Zero tolerance of abuse and neglect of residents, mandatory reporting or Whistle-blower protection.

During an interview with the inspector, staff #S-202 stated that they had no idea of any Ministry phone number to call to report abuse, did not know the term Zero Tolerance, and when asked by the inspector what training in the abuse policy they had received, replied "not that I'll remember but I think there are monthly papers";
-Staff #S-26 told the Inspector that they don't remember training on abuse policies.

On October 16, 2014 staff #S-303 told Inspector #580 that staff #S-301 stated that the Home does not provide staff training on mandatory and immediate reporting of abuse. (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2015

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Order / Ordre :

The licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations including but not limited to the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26 and infection prevention practices.

Grounds / Motifs :

1. The licensee has failed to ensure that training has been provided for all staff in infection prevention and control. Review of 2013 training and retraining for staff in infection prevention and control identified 280/335 or 84% of staff employed at the home received annual training. Inspector #594 interviewed management staff #S-302 who confirmed the infection prevention and control education attendance. Given only 280 of 335 staff completed training on infection prevention and control, the licensee failed to ensure all staff received training annually. (594)

2. The licensee failed to ensure that all staff have received retraining annually relating to the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and the whistle-blowing protections. Inspector #580 reviewed the home's Residents' Rights: Prevention of Abuse and Neglect policy R7.1.0 dated September 12, 2013 and the Whistle-Blowing Protection: Staff Reporting policy W6.0 dated June 21, 2011 which both state staff members will receive annual re-training on the reporting obligations under the LTCHA, the home's internal procedures for reporting, and the whistle-blowing protections in the

LTCHA.

The inspector reviewed staff #S-211's training records which indicated attendance for training in GPA and training on two of the twenty-seven Residents' Bill of Rights. The Inspector was not able to locate any training records for the home's policy to promote zero tolerance of abuse and neglect of residents, and no training records for the duty to make mandatory reports under section 24 nor training for the whistle-blowing protection.

During and interview with the inspector, staff #S-217 stated they had taken GPA training but probably not within the last year and had no abuse training in 2014; staff #S-215 stated when asked if they had received training on the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 or training for the whistle-blowing protection replied "not that I'll remember but I think there are monthly papers". Staff #S-216 stated they do not remember training on Whistle-blowing protection or abuse policies.

On October 16, 2014 staff #S-303 told Inspector #580 that staff #S-301 stated the home does not provide staff training on mandatory and immediate reporting of abuse and whistle-blowing protections. (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2015

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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is requested to prepare, submit and implement a plan to ensure that for resident #4998, #5063, #5099 and for any other resident where bed rails are used, that the residents have been assessed and their bed system has been evaluated in accordance with evidenced based practices.
This plan is to be submitted to:
Monika Gray (594), Inspector - Nursing
Sudbury Service Area Office
Ministry of Health and Long-Term Care Performance Improvement and Compliance Branch
159 Cedar Street, Suite 403
Sudbury ON P3E 6A5
by Tuesday February 17, 2015

Grounds / Motifs :

1. The licensee has failed to ensure where bed rails are used, the resident has been assessed and their bed system evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident. Inspector #594 reviewed resident #4998, #5063 and #5099 health care record's and was unable to locate a bed rail assessment. Inspector #594 interviewed staff #S-213 who stated that registered nurses assess residents for bed rails. Staff #S-202 told the inspector that registered nurses collaborate with family, resident and PSWs to assess residents for bed rails. Inspector #594 interviewed staff #S-303 who stated no assessment for bed rails are completed. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2015

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:

1. Falls prevention and management.
2. Skin and wound care.
3. Continence care and bowel management.
4. Pain management, including pain recognition of specific and non-specific signs of pain.
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Order / Ordre :

The licensee shall ensure that training shall be provided to all staff who provide direct care to residents including but not limited to falls prevention and management and for staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices.

Grounds / Motifs :

1. The licensee has failed to ensure that direct care staff are provided training in falls prevention and management. Inspector #575 asked the home to provide the number of direct care staff who have completed training in falls prevention and management for 2013 and 2014. Staff #S-303 reviewed the home's training records to determine the number of direct care staff who have completed training in falls prevention and management. In 2013 only 101 of 159 staff had completed the annual training and in 2014 only 12 of 159 staff had completed the annual training. The staff member told the inspector that in 2013 the training was in April, therefore the inspector noted that the 2014 training should have been completed in April. (575)

2. The licensee has failed to ensure training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device. Review of the February 2013 Education on Restraints attendance identified 18 of 159 direct care staff, 11%, received training with only registered staff attending and no attendance by unregulated health care providers. Review of the 2014 Education on Restraints attendance numbers provided by staff #S-303 identified only 12 of 165 employees, 7%, received training. Inspector #594 interviewed staff #S-303 who confirmed the restraint education attendance. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2015

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee shall ensure that no person performs their responsibilities before receiving training including but not limited to the protections afforded by section 26.

Grounds / Motifs :

1. The licensee failed to ensure that staff receive training in the area of whistle-blowing protections afforded under section 26, prior to performing their responsibilities. Inspector #580 reviewed the home's Employee Orientation Checklist (undated) which states staff are to read and understand the home's various policies but fails to identify Whistle-Blowing Protection. The inspector reviewed the home's Whistle-Blowing Protection: Staff Reporting policy #W6.0 dated June 21, 2011 which states staff members will receive orientation and annual re-training on the reporting obligations under the LTCHA, the home's internal procedures for reporting, and the whistle-blowing protections in the LTCHA.

During an interview with the inspector, staff #S-217 stated they did not know about whistle-blowing protection; staff #S-215 stated they did not know the name of whistle-blowing protection but knew that there would be protection from their union if they got in trouble for reporting; staff #S-202 stated they had no idea that there was protection for the person reporting abuse; and staff #S-216 stated they remember attending an in-service seven months ago on harassment but does not remember training on whistle-blowing protection or abuse policies.

On October 16, 2014 staff #S-303 told Inspector #580 that staff #S-301 stated that the home does not provide staff training on whistle-blowing protections. (580)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2015

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Order / Ordre :

The licensee shall ensure that:
1. only a physical device, that has been ordered by or approved by a physician or a registered nurse in the extended class, is applied to resident #5100 and any other resident;
2. all hourly monitoring of resident #5103 and any other resident while being restrained is documented and
3. the written policy to minimize restraining of residents identifies all types of physical devices permitted and the policy is complied with.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and that the policy is complied with. Inspector #594 observed resident #5063 with two full padded side rails in use on October 07, 2014 and resident #4998 with two full side rails in use on October 09, 2014. Staff #S-213 told the inspector that both residents are physically unable to get out of bed and the bed rails are used for safety so they do not fall out of bed. Staff #214 told the inspector that bed rails are used for both residents so they do not fall out of bed and that both residents are physically unable to release the bed rail or have the mobility to get out of bed.

Inspector #594 reviewed the care plans for residents #5063 and #4998. The care plan for resident #5063 stated Bed rails: Two full rails up at all times. Bed rail covers x2. The care plan for resident #4998 stated Bed rails: x2 rails.

Inspector #594 reviewed the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 which stated: The use of a physical device, from which a resident is able to both physically and cognitively release themselves, is

not a restraining device. The definition of a physical restraint is any manual method, or any physical or mechanical device, material or equipment that is attached or adjacent to the resident's body, that the resident cannot remove and that restricts the resident's freedom of movement or normal access to his or her body. Devices not defined as restraints and don't require doctor's order include but not limited to partial bed rails.

In an interview with the inspector, staff #S-303 and #302 stated that the restraint policy does not clearly address bed rails as restraints in the home.

During the Resident Quality Inspection, Inspector #575 observed resident #5100 sleeping in a wheelchair with a restraint applied with no current order as told to the inspector by staff #S-219. Review of the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 states staff are to apply restraint as ordered and document reaction. Inspector #575 also reviewed resident #5103's health care record and noted the resident was ordered a restraint while in wheelchair and to document when restraint is used and monitor, every hour. Staff #S-221 opened the resident record on Point Click Care and told the inspector that the documentation of the monitoring of restraints was only required every shift according to Point of Care. Review of the home's Least Restraint Policy and Procedure – Decision Tree policy #R6.2.0 states registered staff are to update Care Plan to identify type of restraint and use, and activate the documentation for unregistered staff in Point of Care.

Given the following: 1. that a physical device was applied to resident #5100, that had not been ordered or approved by a physician or a registered nurse in the extended class; 2. that all assessments, reassessments and monitoring, including resident #5103's response to the restraint failed to be documented every hour and, 3. that the home's restraint policy failed to identify all types of physical devices permitted to be used in the home, the licensee has failed to ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations and that the policy is complied with. [s. 29.] (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2015

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 : 008

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee shall ensure that 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: 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.

Grounds / Motifs :

1. The licensee has failed to immediately report to the Director where there are reasonable grounds to suspect abuse of a resident. Inspector #594 reviewed a Complaint Documentation Form and Interdisciplinary Conference notes where a family member of resident #4998 brought forward, in an interdisciplinary conference, a concern that staff #S-211 was rough with resident #4998 during the resident's bath and when being rolled and turned and positioned for transfer. The licensee failed to recognize this as alleged abuse being brought forward, for which the licensee is required to report immediately to the Director. This report to the Director is not contingent upon the licensee completing its investigation or validating the allegation. A documented pattern of inaction regarding reporting certain matters to the Director on the part of the licensee is evidenced by non-compliance issued during inspections in 2011, 2012 and 2013. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 13, 2015

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 4th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Monika Gray

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