Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 27, 2015	2015_264609_0043	018505-15	Resident Quality Inspection

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF BRUCE
41 McGivern Street P.O. Box 1600 WALKERTON ON N0G 2V0

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

GATEWAY HAVEN LONG TERM CARE HOME
671 FRANK STREET P.O. BOX 10 WIARTON ON N0H 2T0

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

CHAD CAMPS (609), NUZHAT UDDIN (532), RAE MARTIN (515), RUTH HILDEBRAND (128)

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): August 4, 5, 6, 7, 10, 11, 12, 13, 14, 2015.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, the Recreation and Leisure (R&L) Manager, the Nutrition Manager, the Environmental Services Manager, the Clinical Coordinator, three Housekeepers, one Laundry Aide, two Administrative Assistants (AA), 13 Personal Support Workers (PSW), seven Registered Practical Nurses (RPN), two Registered Nurses (RN), one Dietician, one Dietary Aide, and two Recreation Aides.

The inspector(s) also toured the home, observed meal service, medication passes, medication storage areas, care and activities provided to residents, resident/staff interactions, infection prevention and control practices, postings of required information, general maintenance, cleaning and condition of the home as well as reviewed the home's policies and procedures, clinical records and plans of care, Resident and Family Council meeting minutes, the Resident Satisfaction Survey, and internal investigation reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) A review of clinical records revealed that an identified resident was incontinent of bladder.

A review of the Quarterly Continence Assessment for the identified resident did not address causal factors, type of incontinence or potential to restore function with specific interventions.

An interview with the DOC confirmed that it was the home’s expectation that the continence assessment must address causal factors, type of incontinence and potential for restore function, that the home’s current continence assessment did not address the three cited components and should have. (609)

B) Minimum Data Set (MDS) quarterly review assessment coded an identified resident as frequently incontinent of bladder, tended to be incontinent daily, but some control present (e.g. on day shift).

The next quarterly review assessment coded the identified resident as incontinent- had inadequate control of the bladder, multiple daily episodes of incontinence.

The next Modified Resident Assessment Protocol (RAP)coded the identified resident as fully incontinent of urine and required extensive assistance.

The home's policy titled "Continence Care" dated February 5, 2015, effective date October 18, 2010, indicated that a bladder and bowel assessment was required to be completed by seven days of admission, followed by a change of condition and quarterly with documentation.

A record review revealed that there was a hard copy of section “H” of the MDS completed as an incontinence assessment. However, the assessment did not include

identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

On August 12, 2015, the RAI Coordinator shared that she had been completing section "H" as the incontinence assessment on a quarterly basis for the residents and advised that currently the assessment that was being completed was very simple. She confirmed that the continence assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was not conducted using a clinically appropriate assessment instrument. She further shared that there was another comprehensive assessment that was recently initiated, however, it was only being completed on an annual basis and not quarterly or following any change. (532)

C) A clinical record review for an identified resident revealed that the quarterly MDS assessment indicated the resident had deterioration in bladder continence. The Clinical Coordinator confirmed that section "H" of the MDS was the continence assessment.

The Clinical Coordinator acknowledged during an interview, on August 12, 2015, that the home's continence care assessments did not include causal factors, types of incontinence and potential to restore function and that they needed to review this at the next continence care meeting. (128) [s. 51. (2) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that where the Act or this Regulation required the Licensee of a long-term care home to have, institute or otherwise put in place a policy that it was in compliance with and was implemented in accordance with applicable requirements under the Act.

A review of the home's policy titled "Skin Integrity and Wound Care" effective date January 5, 2005, revealed no mention that residents exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds must have their skin reassessed at least weekly by a member of the registered staff.

An interview with the DOC confirmed that the policy was not in compliance with the Long Term Care Home's Act and or the Regulation related to weekly skin reassessments and should be. The DOC confirmed that the cited policy would be updated to include weekly skin assessments. [s. 8. (1) (a),s. 8. (1) (b)]

2. The Licensee has failed to ensure that any policy instituted was complied with.

Clinical record reviews conducted throughout the Resident Quality Inspection revealed that 27 of 34 (79 per cent) of the residents admitted to the home more than one year ago did not have annual heights taken.

Interviews with three registered staff members confirmed that annual heights had not been taken for all residents.

A review of the policy titled "Measuring Resident's Heights" effective date July 20, 2015, indicated that residents were to be measured for heights upon admission, during the admission process and were to be remeasured annually.

In an interview, on August 13, 2015, the DOC acknowledged that she was not aware until recently that residents required annual heights to be taken, and indicated that she developed a new policy in July 2015 to comply with the Regulation.

The DOC confirmed that the licensee did not ensure that the policy was complied with as annual heights were not taken for all residents. [s. 8. (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place a policy that it is in compliance with and is implemented in accordance with applicable requirements under the Act as well as to ensure that any policy instituted is complied with, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations made during the initial tour and throughout the Resident Quality Inspection, revealed:

a) Damaged, patched and paint chipped walls in the tub rooms of all four (100%) resident home areas.
b) Damaged and paint chipped doors, door frames, walls and baseboards in 15 of 40 (37.5 per cent) of resident rooms as well as in common areas in all four home areas.
c) Wooden door for an identified resident's room was gouged and splintered with sharp areas of wood exposed posing a potential risk to the resident.
d) Wooden legs and frame of a sofa located across from the dining room on a second floor home area had damaged and scraped wood with sharp edges exposed. The underside of the sofa was ripped and hanging below the sofa.
e) Wallpaper was peeling off the wall below a window on a third floor home area.
f) 25 ceiling tiles were visibly stained in common areas throughout the home.

During a tour of the home on August 11, 2015, the observations were verified by the Maintenance Supervisor and the Administrator.

The Administrator also confirmed the expectation that the home, furnishings and equipment were to be maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home were immediately forwarded to the Director.

A letter from a family member of an identified resident was received by the home on a specified day which alleged a PSW treated the resident inappropriately.

An interview with the DOC confirmed that the letter was not immediately forwarded to the Director. A review of the requirements under the Act was conducted with the DOC who confirmed that it was the home's expectation that all written complaints were immediately forwarded to the Director that have been received concerning the care of a resident or the operation of the home and in the case of the written complaint received by the home on a specified day, it was not forwarded and should have been. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any written complaints that have been received concerning the care of a resident or the operation of the home is immediately forwarded to the Director, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations on a specified day of an identified resident revealed altered skin integrity.

A review of the clinical records revealed that the altered skin integrity was related to a diagnosed illness. From the date of diagnosis approximately four weekly skin assessments should have been completed. Clinical records revealed only one weekly assessment was completed during the specified time frame.

An interview with registered staff revealed that it was the home's expectation that the altered skin integrity of an identified resident should have had a weekly skin assessment.

An interview with the DOC confirmed that it was the home's expectation that a resident exhibiting altered skin integrity was to receive a weekly skin assessment and in the case of an identified resident this did not occur and should have. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The Licensee has failed to ensure that all hazardous substances at the home were labeled properly and were kept inaccessible to residents at all times.

Observations on August 4, 2015, during the initial tour of the home, revealed the treatment room door on the Saugeen Home Area was open and the room was unattended. A bottle of antibacterial All Purpose Cleaner was in the cupboard under the sink. The bottle was labeled "Do not drink".

In an interview, the RAI Coordinator confirmed the observation and acknowledged that a hazardous chemical was accessible to residents.

In an interview, the Administrator confirmed the expectation that all hazardous substances at the home were to be kept inaccessible to residents at all times. [s. 91.]

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 hazardous substances at the home are labeled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure the resident's right to be treated with courtesy and respect was fully respected and promoted and in a way that fully recognized their individuality and respected their dignity.

On specified days an identified resident reported a staff member acted inappropriately.

A review of the clinical record revealed that a progress note documented on a specified day revealed that the resident was agitated with staff related to staff conduct.

On August 12, 2015, the DOC acknowledged that identified conduct of staff was inappropriate and confirmed that the resident was not treated with courtesy and respect and that their dignity was disrespected. [s. 3. (1) 1.]

WN #8: 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. (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 provided to the resident was as specified in the plan.

A review of the plan of care for an identified resident revealed that the resident was to receive an identified intervention.

A review of progress notes revealed that the resident did not receive the identified intervention.

An interview with the Clinical Coordinator confirmed that the care set out in the plan of care was not provided as the resident was to receive an identified intervention and in the case of the 2012-2015 calendar years the resident did not receive the identified intervention and should have. [s. 6. (7)]

2. The Licensee has failed to ensure that residents were reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed or care set out in the plan was no longer necessary.

A) A review of the plan of care for an identified resident revealed that the resident had an identified intervention related to a medical diagnosis.

Observations made throughout the Resident Quality Inspection revealed the identified resident did not receive the identified intervention.

An interview with registered staff revealed that the identified resident did not receive the identified intervention since admission.

An interview with the Clinical Coordinator confirmed that the identified resident has never received the identified intervention as part of care, that the plan of care was not revised when the care set out in the plan of care was no longer necessary and in the case of the identified intervention the plan of care should have been revised which did not occur.

B) A review on August 11, 2015, of the plan of care for an identified resident revealed an outdated identified intervention to provide a visual cue for the staff, indicating the fall risk to the resident.

Observations on August 11, 2015, revealed that the identified resident had a different intervention in place to provide a visual cue for the staff, indicating the fall risk to the resident.

A review of the Falls Prevention Management Program included a memo from the Clinical Coordinator identified a new identified intervention to provide a visual cue for the staff, indicating the fall risk to the resident.

Observations on August 11, 2015, revealed the outdated identified intervention was posted on the care guide inside the resident's room.

In an interview on August 12, 2015, the Clinical Coordinator reported that the fall risk assessment tool was completed quarterly to determine if a resident was at low/moderate or high risk for falls.

The Clinical Coordinator acknowledged that it was the home's expectation that a reassessment should have been completed back in June 2015 to determine the level of risk for an identified resident, that it was not completed and confirmed that the plan of care was not reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary. (532) [s. 6. (10) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that each resident of the home had his or her personal items including personal aids such as dentures, glasses and hearing aids were labeled within 48 hours of admission and when acquired, in the case of new items.

Observations of 24 shared resident bathrooms revealed five (21 per cent) had unlabeled personal care items such as toothbrushes, hairbrushes and toothpaste.

An interview with personal support staff confirmed that it was the home's expectation that all personal care items were to be labeled.

An interview with the DOC confirmed that there was no policy in the home which explicitly instructed staff to label personal care items within 48 hours of admission and and when new items were received. The DOC confirmed that the home's policy would be updated and confirmed the home's expectation that all personal care items were to be labeled within 48 hours of new items being received and in the case of the five cited residents this did not occur and should have. [s. 37. (1) (a)]

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The Licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

A review of the Family Council meeting minutes revealed no indication that the Family Council was consulted in the development or implementation of the 2015 resident satisfaction survey.

An interview with the R&L Manager confirmed that it was the home's expectation that the Family Council be consulted in the development and implementation of the resident satisfaction survey and in the case of the 2015 survey this did not occur and should have. [s. 85. (3)]

Issued on this 3rd day of September, 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609), NUZHAT UDDIN (532), RAE MARTIN (515), RUTH HILDEBRAND (128)
Inspection No. / No de l'inspection :	2015_264609_0043
Log No. / Registre no:	018505-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 27, 2015
Licensee / Titulaire de permis :	CORPORATION OF THE COUNTY OF BRUCE 41 McGivern Street, P.O. Box 1600, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	GATEWAY HAVEN LONG TERM CARE HOME 671 FRANK STREET, P.O. BOX 10, WIARTON, ON, N0H-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHARLES YOUNG

To CORPORATION OF THE COUNTY OF BRUCE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The Licensee must ensure compliance with O. Reg. 79/10, s. 51 (2) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

The Licensee must ensure that all residents who are incontinent in the home receive an incontinence assessment using a clinically appropriate assessment instrument.

The licensee must ensure that all registered staff of the home receive training on continence assessments, including when a resident should receive an assessment and how to conduct a continence assessment.

Grounds / Motifs :

1. The Licensee has failed to ensure each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

A) A review of clinical records revealed that an identified resident was incontinent of bladder.

A review of the Quarterly Continence Assessment for the identified resident on a specified day, did not address causal factors, type of incontinence or potential to restore function with specific interventions.

An interview with the DOC confirmed that it was the home's expectation that the continence assessment must address causal factors, type of incontinence and potential for restore function, that the home's current continence assessment did not address the three cited components and should have. (609)

B) Minimum Data Set (MDS) quarterly review assessment on a specified day, coded an identified resident as frequently incontinent of bladder, tended to be incontinent daily, but some control present (e.g. on day shift).

Quarterly review assessment on a specified day, coded the resident as incontinent- had inadequate control of the bladder, multiple daily episodes of incontinence.

The Modified Resident Assessment Protocol (RAP) on a specified day, stated that the resident was fully incontinent of urine and required extensive assistance.

The home's policy titled "Continence Care" dated February 5, 2015, effective date October 18, 2010, indicated that a bladder and bowel assessment was required to be completed by seven days of admission, followed by a change of condition and quarterly with documentation.

A record review revealed that there was a hard copy of section “H” of the MDS completed as an incontinence assessment. However, the assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

On August 12, 2015, the RAI Coordinator shared that she had been completing section “H” as the incontinence assessment on a quarterly basis for the residents and advised that currently the assessment that was being completed was very simple. She confirmed that the continence assessment did not include identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was not conducted using a clinically appropriate assessment instrument. She further shared that there was another comprehensive assessment that was recently initiated, however, it was only being completed on an annual basis and not quarterly or following any change. (532)

C) A clinical record review for an identified resident revealed that the quarterly MDS assessment, conducted on a specified day, indicated the resident had deterioration in bladder continence. The Clinical Coordinator confirmed that section "H" of the MDS was the continence assessment.

The Clinical Coordinator acknowledged during an interview, on August 12, 2015, that the home’s continence care assessments did not include causal factors, types of incontinence and potential to restore function and that they needed to review this at the next continence care meeting. (128) (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 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 27th day of August, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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