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
Dec 2, 2014	2014_333577_0010	S-000247-14	Resident Quality Inspection

Licensee/Titulaire de permis

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

GERALDTON DISTRICT HOSPITAL
500 HOGARTH AVENUE WEST GERALDTON ON P0T 1M0

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

DEBBIE WARPULA (577), KARI WEAVER (534)

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): July 7, 8, 9, 10, 11, 14, 15, 16, 17 & 18, 2014.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Nursing Manager, Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Infection Control Manager, Registered Dietitian, Housekeeping Manager, Manager of Support Services, Housekeeping staff, Dietary Aides (DA), Activity Staff, Maintenance Staff, Ward Clerk, Accounts Clerk, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Trust Accounts

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

14 WN(s)
3 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. 53. Responsive behaviours

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #534 reviewed the home's responsive behaviors program as a result of a medication being administered to resident #973 and resident #975. Inspector interviewed staff member #S-115 about the home's responsive behaviors program and it was determined during the interview that the home did not have a responsive behaviors program in place. Currently, when a resident was displaying responsive behaviors the nursing staff were not in the practice of initiating or starting a "DOS" as a part of their routine practice. According to #S-115, the "DOS" were initiated by the home's social worker for the nursing staff to document on. #S-115 explained that behaviors were addressed on a resident to resident basis according to incident reports brought forward.

The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviors: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required. [s. 53. (1) 1.]

2. Inspector #577 reviewed care plan for resident #612 relating to responsive behaviors. Resident wanders into other residents rooms,and displays responsive behavior towards other residents, most recently, displaying behavior toward resident #961. Inspector spoke with staff member #S-120 concerning resident's responsive behavior, who reported they try to keep resident away from other residents' rooms, attempt to keep them busy with activities in dining room and staff try to re-direct them and walk with them. Inspector spoke with staff member #S-101 about resident's responsive behavior, who reported they are aware of behavior and staff will try to re-direct them by involving resident in activities and bringing them into dining room. Inspector spoke with staff member #S-114 who reported that the home does not have a Responsive behavior program. It was further reported the current process is for staff to contact the Social Worker who initiates a DOS tool to track behavior of residents showing responsive behavior.

The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviors: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1). [s. 53. (1) 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 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. Inspector #534 observed gaps between the upper and lower side rails that were in use for resident #976 and resident #564. The inspector noted the gap between where the upper rail met the lower rail to be approximately 40-50cm. Inspector interviewed staff member #S-115 to determine if the home assessed bed rail safety in the home. #S-115 reports that the home was in the process of reviewing different tools to address bed rail safety but did not have anything in use at this time.

The licensee failed to ensure that where bed rails are used,(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. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that where bed rails are used,(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., to be implemented voluntarily.

WN #3: 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. Inspector #577 observed an unattended and unlocked housekeeping cart sitting outside staff bathroom. Inspector watched staff member #S-104 walk into bathroom and shut door. A few minutes later, #S-104 walked out of bathroom. Inspector requested to see chemicals on unlocked cart. Inspector observed bottles of Ozium air sanitizer, Total washroom cleaner, Virox 5, ElimO, Virex 256, Crew Super Blue, Glance glass cleaner, Javex, Stride HC cleaner, MegaSorb plus chlorinated super absorbent and sanitizer, Zochlor chlorine disinfectant tablets, and disinfectant cleanser IV. Also, a pail of water mixed with Virex 256 sitting on top of cart. Spoke with staff member #S-104 and they report that they should not have left cart unattended. One hour later, Inspector observed an unattended and unlocked housekeeping cart with hazardous chemicals were in resident hallway outside a resident room. Staff member #S-104 reported that they were trained that it is acceptable to leave the cart in the hallway and they do not have keys to lock their carts. Inspector spoke with staff member #S-116 and informed them of unlocked housekeeping carts with multiple hazardous chemicals being left unattended. #S-116 reports they weren't aware that carts were not being locked and will have the carts locked. #S-116 reports that maintenance had changed the locks and staff were not trained to leave carts unattended when unlocked and should be locked at all times. Reports they will resolve this right away.
The licensee failed to 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. [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 labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91., to be implemented voluntarily.

WN #4: 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).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. Inspector #534 noted an isolation cart outside of a resident's room and inquired about the isolation status and precautions that would be required by the inspector to enter the resident's room. The inspector spoke with staff member #S-112 about resident #975 isolation diagnosis. #S-112 reported to the inspector that they were unsure exactly what the organism was or where. A few minutes later the inspector asked staff member #S-105 about the isolation diagnosis and precautions for the resident. #S-105 stated that they would have to look up the diagnosis since they did not know and did not have time to look up the status. The #S-105 stated "I'd have to do some research on that one. If you give me about 2 hours I can get back to you". Both staff members were unable to assist or provide the inspector with information required prior to entering the resident's room.

The licensee has failed to ensure that all staff participate in the implementation of the

program. [s. 229. (4)]

2. Inspector #577 observed staff member #102 enter resident's #001 room and administer three oral medications. Staff member failed to wash their hands prior to entering room and administering medication. Inspector observed staff member wash their hands after leaving resident's room. Inquired about Homes expectation on hand washing and medication administration. Reports they should have washed their hands prior to entering room and giving medication. [s. 229. (4)]

3. Inspector #534 interviewed staff member #S-118 about the home’s immunization and screening program for residents in the home. Staff member stated that the home offered residents pneumoccocus, tetanus, and diphtheria in accordance with the publicly funded immunization schedules. Inspector reviewed the immunization records for resident #975, #965,and #951. Inspector was unable to locate the documentation of tetanus immunization being offered or administered to all three of the residents. This was confirmed by the inspector through additional interviews with staff member #S-114 and staff member #S-115. Tetanus was not listed under vaccinations on the home’s "Admission to Long-Term Care Pre-Printed Medical Order" set or on the home’s resident "Admission Checklist". Tetanus was listed on the “Resident Profile” paper document. No documentation of tetanus administration was found by the staff member #S-114 on the home’s computer documentation system and stated that home does contact public health for documentation records of residents but thinks tetanus has not been offered since the focus has been on the pneumovax and flu shot immunizations.

The licensee shall ensure that the following immunization and screening measures are in place: 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 3.]

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 program and to ensure that the following immunization and screening measures are in place: 3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website., to be implemented voluntarily.

WN #5: 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. Inspector #534 observed the care provided to resident #591 on four separate days. Inspector noted little communication occurring between the staff and resident and observed the resident to be unkempt in appearance. Inspector made the following observations:
During a lunch meal observation, residents #591 eyes matted with yellow crusty drainage and yellow crusty debris on face and clothing protector. Staff member #S-105 was sitting at table with resident and did not offer to wash resident's face.
During a supper meal observation, the hair on the back of residents #591 head was

messy and tangled.
During another lunch observation, resident #591 was wearing the same clothing protector from morning meal. Inspector observed a new clean clothing protector folded on the table in front of resident. Staff did not put a new clean clothing protector on resident for lunch meal. The clothing protector on resident #591 was observed to have dried debris on it prior to the serving of lunch. Resident's eyes noted to have crusty drainage.
During another supper observation,at 1750 pm, inspector observed resident #591 to have food debris on right side of chin and large amount of spilled food on clothing protector and shirt. Resident was sitting alone at assigned dining table with no personal support staff present for approximately 35 minutes. Dietary staff were in the dining room at the time.
During a breakfast observation,resident #591 was in dining room with empty cups in front of them, clothing protector on, both eyes with crusty drainage, and eggs on chin and clothing protector for approximately 30 minutes. Staff member #111 approached resident to escort them to their room. Inspector asked #S-111 why resident has been left unclean and sitting for extended time periods after completion of the meal services, with face unclean and clothing protector left on. #S-111 reported that staff leave the resident so they are relaxed and less likely to resist care and that the resident often becomes combative and resists care. Personal care was not offered to resident #591 after the completion of their meal for approximately 30 minutes during meal observations. The inspector did not observe the resident #591 to resist care when offered or during staff resident interactions. In the resident's care plan, it outlined that if the resident was agitated when approached by staff, staff are to leave the resident and return at a later time. This initial approach was not observed by the inspector after meals. The resident was observed to be calm, quiet, and cooperative with staff interactions both during and after the meal times.

The licensee has failed to ensure that the following rights of residents are fully respected and promoted: every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. [s. 3. (1) 4.]

WN #6: 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).

Findings/Faits saillants :

1. Resident #976 was identified as having weight loss. Inspector #577 noted a declining weight over last 6 months as follows: January/77.1 kg, February/74.6 kg, March/72.8 kg, April/75.8 kg, May/72.9 kg, June/74.3 kg. Total loss of 2.8 kg. On a particular day, at 1206 pm, Inspector #577 observed resident #976 sleeping in bed and refusing lunch. At 12:18 pm, Inspector spoke with staff member #S-106, who reports resident doesn't want to get up for lunch, and staff will feed him later. At 1303 pm, Inspector observed resident in their room and no lunch being offered. At 13:37 pm, Inspector spoke with staff member #S-101 and inquired if resident had lunch today and staff member reports the resident refused twice. Inspector inquired about what approach is used when resident refuses lunch. They report that resident likes bananas, and they will bring him one. At 1421 pm, staff member reports they gave resident a muffin and banana and resident ate the snack. Resident was not offered boost. Care plan reads that if resident is refusing to get up for a meal, give boost 237ml. Inspector reviewed the dietary notes which indicated that resident eats 75% of his meals. Current weight is 74.3 kg, an increase of 1.5kg in last 3 months. Average intake of fluids is 1347 ml/day and Boost if no meal. Reviewed interdisciplinary team meeting minutes for resident. Reads that resident refuses many meals, lays in bed all day. Weight 74.5 kg, increased 1.5 kg in 3 months. Inspector reviewed the quarterly assessment which reads that resident refuses majority of their meals, states they are not hungry. Enjoys bananas, family often bring him pop and chips, marshmallows, chocolate bars. Resident has a poor appetite, often refuses meals, has lost significant weight in past few months and is on a medication pass. Reviewed dietary sheet and resident is ordered a dental soft cardiac diet, regular toast, med pass 2 oz qid, offer full boost if resident refuses meal. Nutritional risk: High-significant weight loss, limited intake at meals, need of supplements.
Inspector spoke with staff member #119 regarding recommendations for missed meals. Care plan reads that if resident is refusing to get up for a meal, give boost 237 ml. Staff member reports that giving a supplement has more nutrition than a snack, such as banana and muffin. Inspector explained that resident missed lunch the previous day and did not receive his boost. #S-119 report there isn't a process in place to track if boost is given for missed meals.

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

WN #7: 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. On two separate days, Inspector #577 observed the wheelchair belonging to resident #953. The cushion, seat belt and wheels were soiled and stained with food. Inspector spoke with staff member #S-103, who reports that it is the night staff responsibility to clean wheelchairs. Inspector reviewed the "Nightly Staff Quality Improvement Checklist" which reads that night staff are to clean wheelchairs according to a monthly schedule.

The licensee failed to ensure that sure that, (a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2). [s. 15. (2) (a)]

2. Inspector #534 noted many areas of disrepair within the home. Observations of disrepair included:
-residents #975 bathroom door jamb in disrepair and paint scraped away
-residents #976 entry door jamb into room missing plastic protective strip and bathroom door jamb missing lower corner protector, with both door jambs very scratched and scraped
-residents #965 bathroom wall had 2 holes at entrance, approximately 3cm in diameter with exposed drywall fragments, many sections of protective corner trim missing in room with exposed glue, drywall, and metal noted. Resident's ceiling lift missing cover, observed to have wires and motor exposed and open
Inspector interviewed staff member #S-117 about the home's preventative maintenance program. They stated that the home has maintenance goals and are done according to what receives funding approval. The home has been working on larger capital projects such as improving the acute hospital side washroom accessibility and installing a new back-up generator for the home and hospital. Staff member stated that as a result, they have been unable to complete much of the preventative maintenance as they would like.

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. Inspector #577 reviewed care plan for resident #953 concerning oral care. Care plan reads that resident is to continue to see the dentist q3months for follow up appointments to prevent serious complications, as resident is high risk for oral abscesses. Review of chart indicates that last dental assessment by dentist was March 2013. Resident had a dental appointment on December 4, 2013 and resident refused to go to appointment, staff member #S-100 to reschedule. Inspector spoke with staff member #S-100 and reports they had neglected to re-schedule any follow-up appointments.

The licensee failed to ensure that (c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1). [s. 34. (1) (c)]

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. During a tour of the home, inspector #534 made note of multiple unlabelled personal care items for various residents. In a shared bathroom for resident #002 & #952, Inspector observed one unlabelled plastic green denture container on the counter top and one toilet seat hat propped in the upside down position on the toilet seat drying. The inspector talked to staff member #S-109 concerning which unlabelled items belonged to which resident. The staff member stated that "staff just know" and that personal care items are not normally labelled in the home.

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labeled within 48 hours of admission and of acquiring, in the case of new items. [s. 37. (1)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. Inspector #534 was looking into the home's pain program due to resident #975 complaints that the pain medication they receive was not always effective. The inspector

spoke with staff member #S-115 about the home's pain program. Staff member reports that the home does not have a pain management program in place and is in the early stages of development. Currently a resident's pain is documented on the medication administration records (MARs) and e-notes. Staff member #S-115 further noted that resident's pain should be addressed in the resident's plan of care.

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [s. 52. (2)]

2. Inspector #577 reviewed care plan for resident #961 relating to pain. Resident suffers daily with chronic pain. Resident receives scheduled and prn pain medication and a topical rub prn. Inspector spoke with staff member #S-106, who reports they are unaware of a specific pain management program, but document a quarterly pain assessment. #S-106 also reports Home's expectation on pain management is that they should be assessing for pain everyday. Inspector spoke with staff member #S-115, who reports that Home does not have a pain management program. #S-115 reports it is in process, and a tool kit has been ordered and that staff are to document on MARS and E-notes for pain interventions.

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2). [s. 52. (2)]

3. Inspector #577 reviewed care plan and medication records for resident #564 relating to pain. Resident suffers from daily chronic pain and may receive scheduled and prn pain medication. Inspector spoke with staff member #S-106 about pain management. #S-106 reports resident receives pain medication at 0800 hr and 1700 hr. #S-106 reports resident will ask for a topical rub if having pain, and wears a brace for support. #S-106 reports they are unaware of a specific pain management program, but they do quarterly pain assessments and also reports Home's expectation on pain management is that they should be assessing for pain everyday. On a particular day, at 09:46 hr, resident was up ambulating in hall. Inspector inquired about the resident's pain. Resident reports pain is 10/10 and that they haven't received any pain medication this morning. At 1048 hr, Inspector spoke with resident about pain. Resident reports they haven't received anything for pain and rates pain as 10/10. At 1203 hr, resident reports pain is somewhat relieved, rates as 5/10. Resident reports they received pain medication. At 1314 hr, resident reports pain is 10/10. Inspector informed staff member #S-106 that resident

requires pain medication. #S-115 confirmed to inspector through an interview that the Home does not have a pain management program. #S-115 reports it is in the process and a tool kit has been ordered. #S-115 reports that staff document on MARS and E-notes for pain interventions.

The licensee has failed to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2). [s. 52. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Inspector #534 conducted an interview with resident #564, identified as the Resident Council President. A family member of resident #003 often attends the Residents' Council meetings. The inspector noted that during the review of meeting minutes, the family member was documented as having attended multiple Residents' Council meetings.

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

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. Inspector #534 spoke with staff member #S-115 to determine whether a Family Council was organized within the home. It was determined through conversation that a Family Council did not exist nor did the home offer or advise families and persons of importance to the residents of their right to establish a Family Council. Currently, the manager of the long term care home organizes and directs family meetings that facilitate communication between the home and families. No family led or organized meetings exist in the home.

The licensee failed to ensure that, (a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. [s. 59. (7) (a)]

WN #13: 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. Inspector #577 observed staff member #S-102 administer an injectable medication to resident #001 using improper technique. #S-102 injected pen into flat, non-pinched skin. Janzens pharmacy and procedures manual, p. 89 for insulin administration states, "grasp and pinch a cushion of flesh, hold syringe with needle bevel side up and insert at a 45 degree angle". Staff member failed to demonstrate proper technique in accordance with home's own written procedure when inserting insulin pen.

The licensee failed to ensure that 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 (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). [s. 114. (3) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 241. Trust accounts

Specifically failed to comply with the following:

s. 241. (7) The licensee shall,
(f) provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement; and O. Reg. 79/10, s. 241 (7).

Findings/Faits saillants :

1. Inspector #534 was told through a family interview that the home was not providing trust account written statements for residents and their families. The resident or person acting on behalf of a resident had to request statements and they were not automatically provided by the home. The inspector interviewed staff member #S-113 who confirmed no statements were currently provided by the home that outlined deposits, withdrawals, and account balances and the home only sent out invoices when trust account funds were low.

The licensee has failed to provide to the resident, or to a person acting on behalf of a resident, a quarterly itemized written statement respecting the money held by the licensee in trust for the resident, including deposits and withdrawals and the balance of the resident's funds as of the date of the statement. [s. 241. (7) (f)]

Issued on this 4th day of December, 2014

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) :	DEBBIE WARPULA (577), KARI WEAVER (534)
Inspection No. / No de l'inspection :	2014_333577_0010
Log No. / Registre no:	S-000247-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 2, 2014
Licensee / Titulaire de permis :	GERALDTON DISTRICT HOSPITAL 500 HOGARTH AVENUE WEST, GERALDTON, ON, P0T-1M0
LTC Home / Foyer de SLD :	GERALDTON DISTRICT HOSPITAL 500 HOGARTH AVENUE WEST, GERALDTON, ON, P0T-1M0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

To GERALDTON DISTRICT HOSPITAL, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Grounds / Motifs :

1. Inspector #577 reviewed care plan for resident #612 relating to responsive behaviors. Resident wanders into other residents rooms, and displays responsive behavior towards other residents, most recently, displaying behavior toward resident #961. Inspector spoke with staff member #S-120 concerning resident's responsive behavior, who reported they try to keep resident away from other residents' rooms, keep the resident busy with activities in dining room and staff try to re-direct them and walk with resident. Inspector spoke with

staff member #S-101 about resident's responsive behavior, who reported they are aware of behavior and staff will try to re-direct resident by involving them in activities and bringing resident into dining room. Inspector spoke with staff member #S-114 who reported that the home does not have a Responsive behavior program. It was further reported the current process is for staff to contact the Social Worker who initiates a DOS tool to track behavior of residents showing responsive behavior.

The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviors: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1). (577)

2. Inspector #534 reviewed the home's responsive behaviors program as a result of a medication being administered to resident #973 and #975. Inspector interviewed staff member #115 about the home's responsive behaviors program and it was determined during the interview that the home did not have a responsive behaviors program in place. Currently, when a resident was displaying responsive behaviors, the nursing staff were not in the practice of initiating or starting a "DOS" as a part of their routine practice. According to #S-115, the "DOS" were initiated by the home's social worker for the nursing staff to document on. #S-115 explained that behaviors were addressed on a resident to resident basis according to incident reports brought forward.

The licensee has failed to ensure that the following are developed to meet the needs of residents with responsive behaviors: 1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioral triggers that may result in responsive behaviors, whether cognitive, physical, emotional, social, environmental or other. 2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviors. 3. Resident monitoring and internal reporting protocols. 4. Protocols for the referral of residents to specialized resources where required. (534)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 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 2nd day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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