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 prévue le Loi de 2007 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2016;	2015_273580_0006 (A1)	029405-15	Resident Quality Inspection

Licensee/Titulaire de permis

The Corporation of the City of Timmins
481 Melrose Blvd. TIMMINS ON P4N 5H3

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

GOLDEN MANOR
481 MELROSE BOULEVARD TIMMINS ON P4N 5H3

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The Licensee requested an extension to the compliance date for Compliance Order #002 from January 29, 2016 to February 29, 2016.

Issued on this 19 day of January 2016 (A1)

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

Original report signed by the inspector.

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): November 2 - 6 and 9 - 12, 2015.

The following inspections were carried out concurrently with the RQI: a Complaint regarding abuse, a Complaint regarding falls, two Critical Incidents regarding respiratory outbreaks, three Critical Incidents regarding abuse, and a Follow-Up to an Order from February 2015.

The inspectors reviewed health care records including plans of care, the home's internal investigation reports, complaint reports, critical incident reports, the home’s policies and procedures, components of employee human resource files and training logs, and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

During the course of the inspection, the inspector(s) spoke with residents, Substitute Decision Makers (SDM), Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Resident Service Worker (RSW), a Housekeeping Aide (HA), the Dietary/Housekeeping/Laundry Supervisor (DHLS), the Registered Dietitian, the Maintenance Staff (MS), the Maintenance Supervisor- Environmental Services Supervisor (ESS), the Scheduling Clerk (SC), the Administrative Assistant (AA), the Resident Support Supervisor (RSS), the Nurse Practitioner (NP), the Infection Control and Education Coordinator (ICEC), the Nursing Care Coordinator (NCC), the Director

of Nursing (DON), and the Administrator.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Continence Care and Bowel Management

Critical Incident Response

Dining Observation

Falls Prevention

Family Council

Food Quality

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

Residents' Council

Skin and Wound Care

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

12 WN(s)
7 VPC(s)
4 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 75. (3)	CO #001	2014_380593_0019	612

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. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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. The licensee has failed to ensure that the plan of care sest out clear direction to staff and others who provided direct care to resident #006.

Inspector #612 reviewed resident #006's care plan and was unable to find any focus, goals or interventions related to bladder or bowel continence.

The inspector interviewed PSW #116 who explained that resident #006 was continent of bladder and continent of bowel with assistance of two staff. The inspector interviewed RN #108 who explained that information related to resident's bladder and bowel continence should be found in the resident's care plan and confirmed that this information was not in resident #006's care plan. Therefore the care plan did not provide clear direction to staff regarding the resident's bladder and bowel continence. [s. 6. (1) (c)]

2. The licensee has failed to ensure that there is a written plan of care for resident #006 that sets out, clear directions to staff and others who provide direct care to the resident.

On November 4, 2015, Inspectors #603 and #580 observed resident #006 seated in a wheelchair with two different devices in use. The resident was unable to remove either device. On November 4, 2015, Inspector #603, observed resident #006 in bed with the bed rails in the up position.

The inspector conducted an interview with PSW #105, RPN #111 and PSW #116, who all explained that resident #006 used both devices as well as bed rails when in bed.

RPN #111 explained to the inspector that care information should be in the care plan and that there were no care directions for the two devices used by resident #006 or the bed rails.

The inspector conducted an interview with the Nursing Care Coordinator (NCC) who explained that resident #006's care plan did not have directions related to the resident's two devices or bed rails and that the home had "missed this".

Inspector #580 reviewed resident #006's health care record and found no evidence of any direction regarding the above noted devices. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care was based on an assessment of resident #016 and the resident's needs.

In November 2015, Inspector #603 reviewed resident #016's health care record and noted that there was a MORSE Fall Scale Assessment completed and the outcome was that the resident was considered to be at high risk for falls. The resident's health care record also indicated that the resident had sustained a fall. The inspector reviewed the plan of care and in the resident's care plan, there was no focus, goals or interventions related to the resident's high risk for falls.

The inspector interviewed the NCC who explained that at the time of the fall, the resident was considered to be a high risk for falls based a fall scale assessment. The NCC confirmed that this information should have been indicated on the care plan. [s. 6. (2)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

On November 4, 2015, Inspector #603 observed resident #005 sitting in their wheelchair. In resident #005's bedroom, Inspector #603 observed resident #005's bed was raised, both rails were engaged in the up position.

The inspector reviewed the resident's current care plan and Kardex report.

Interventions under the focus for safety and fall prevention related to the resident trying to self-transfer without assistance, included that the bed rails were to be in a down position and safety checks were to be done every 30 minutes.

The inspector interviewed PSWs #100 and #102 who explained that resident #005 required both bed rails up (engaged) while in bed for safety and mobility, and confirmed that staff do not perform safety checks on resident #005, every 30 minutes as per the care plan. [s. 6. (7)]

5. The licensee has failed to ensure that care set out in the plan of care was provided to resident #005 as specified in the plan.

In November 2015, Inspector #603 reviewed resident #005's health care record and noted that the resident fell four times in 2015. According to the progress notes, the resident fell from their wheelchair which had a safety device; however, it did not function. When the resident was put back in the wheelchair, the staff had to apply a different safety device because the other device was not working.

The inspector reviewed the resident's care plan. The interventions included the safety devices, to ensure the devices were working properly every time resident was transferred into wheelchair or bed, and to check the resident every 30 minutes to ensure safety.

On November 5, 2015, Inspector #603 observed resident #005 sitting in their wheelchair, in the hallway, and with no safety device in place.

Inspector #603 interviewed PSW #110 who had positioned the resident in their wheelchair. They explained that they did not know the resident had a safety device, and it was not placed on the resident's chair.

The inspector observed PSW #110 retrieve the device from the resident's room and fasten it to resident's chair without checking to see if it worked. [s. 6. (7)]

6. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Inspector #603 reviewed resident #003's health care record which indicated that the resident fell three times in September and October, 2015. The inspector reviewed the resident's care plan. The care plan had a focus for Risk for Falls and one of the

interventions included was to check the resident every hour to ensure safety.

In November 2015, the inspector interviewed PSW #125 and RPN #126 who explained that the resident had fallen more "in the last while". PSW #125 explained that the resident walks with their walker and the staff were to watch the resident closely as they were prone to fall. The staff further indicated that they used to check and document on the resident every hour to ensure safety and that they no longer do this.[s. 6. (7)]

7. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Inspector #603 observed resident #002 sitting in their wheelchair in the dining room. The resident did not have a seat belt on. The inspector could not find any seat belt on the resident's wheelchair. The inspector interviewed PSW #136 who explained that the resident does not wear a seat belt while sitting in their wheelchair.

The inspector reviewed resident #002's care plan which indicated that the resident is to have a front clip seat belt in place when in wheelchair to maintain core stability and allow resident to self-propel wheelchair. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 004 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. The licensee has failed to ensure that where bed rails were used, the resident and their bed system was evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident.

On November 4, 2015, Inspector #603, observed resident #006 in bed with the bed rails in the up position.

In an interview conducted with Inspector #580, PSW #105, RPN #111 and PSW #116, confirmed that resident #006 had bed rails in the up position when in bed. RPN #111, further explained to the inspector that the assessment for resident #006's use of bed rails had been completed.

In an interview conducted with the inspector, RN #108 explained that resident #006's bed rail assessment was not completed.

The Nursing Care Coordinator stated to the inspector that the home had "missed this".

In November 2015, Inspector #603 interviewed the Director of Nursing (DON) who explained that the home does not have a formal process to evaluate the bed system, where bed rails are used. The DON explained that approximately one month ago, the home started to discuss this requirement and had purchased equipment to check for bed entrapment, however, there were no dedicated personnel or team to make these evaluations and as a result the residents and their bed systems have not been evaluated. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

In November 2015, Inspector #603 reviewed a Critical Incident Report (CI) that was submitted to the Director. Resident #016 was found lying on their back, on the bathroom floor and the resident's bed alarm was ringing faintly. Resident #016 sustained two fractures and subsequently received surgery.

Inspector reviewed the progress notes which indicated that the resident was found in their bathroom in front of the sink, lying on their back. The bed alarm was going off, but very faint and not heard by staff until they entered the room.

In November 2015,the inspector interviewed RPN #137 who was the staff member who found the resident on the bathroom floor in July 2015. RPN #137 explained that after shift report, they walked out of the report room and they could hear a very faint and different alarm and thought the alarm came from a floor below the unit. RPN #137 walked by resident #016's room and heard the bed alarm ringing "very faintly" and observed that resident #016 was not in their bed. RPN #137 opened the resident's bathroom door and found the resident lying on their back on the floor. RPN #137 further explained that they thought perhaps the alarm's battery was low. After the incident, the staff asked management for a better alarm system for resident #016 and the alarm was subsequently replaced.

RPN #137 explained that the staff members are not expected to check for alarm reliability. The Nursing Care Coordinator (NCC) confirmed that the home has no process for checking alarm reliability. The NCC explained that the alarm in question was too low for staff to hear and for this reason, it was changed. [s. 90. (2) (b)]

Additional Required Actions:

CO # - 003 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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

The inspector reviewed the health care records of resident #009 and #010 which indicated respiratory illnesses in July 2015.

The inspector reviewed the home's Respiratory Outbreak Protocols policy as well as the Nursing Daily Report for Infection Control Surveillance policy. The inspector noted conflicting direction related to respiratory illness detection and reporting between the two policies. The Respiratory Outbreak Protocol indicated that the home needed to report to the health unit when two or more residents exhibit two or more of the same symptoms of an acute respiratory infection. The Nursing Daily Report for Infection Control Surveillance policy does not indicate this but directs the staff to report three or more symptoms of illness.

The inspector observed the Nursing Daily Report for Infection Control Surveillance in use in the home's nursing units.

In an interview conducted with RN #108 they explained to the inspector that if there are three or more symptoms of illness, the resident's name and the symptoms are entered on the home's Nursing Daily Report for Infection Control Surveillance.

The Infection Control and Education Coordinator (ICEC) explained to the inspector that the Nursing Daily Report for Infection Control Surveillance was the policy being used and contained the wrong procedure. The ICEC explained that the home should have been using the Respiratory Outbreak Protocols policy.

A telephone interview was conducted with a Public Health Inspector with the Porcupine Health Unit, who was the home's contact for reporting an outbreak of a communicable disease. They stated that two cases (two residents exhibiting two of the same symptoms) of an acute respiratory infection occurring within 48 hours in a geographic area require immediate reporting to the health unit as a suspect respiratory infection outbreak.

The Director of Nursing (DON) confirmed to the inspector that the Nursing Daily Report for Infection Control Surveillance policy contradicts the Respiratory Outbreak Protocols policy which indicates that an outbreak is to be suspected when there are two or more cases of acute respiratory symptoms occurring within 48 hours, in one geographical area. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the respiratory outbreak policies based on legislation and best practices, are complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Inspector #612 reviewed the Critical Incident (CI) Report alleging PSW #128 verbally abused resident #015. Resident #015 reported the incident in December 2014, to RPN #111. Resident #015 reported that PSW #128 told them to 'hurry up' when they were in the washroom and that they 'did not own the bathroom'. Resident #015 reported that they felt like crying due to the mistreatment.

The inspector reviewed the investigation notes provided by the Nursing Care Coordinator in which PSW #128 admitted to rushing resident #015 and saying the things that the resident reported.

The inspector interviewed Scheduling Clerk #133 and Administrative Assistant #134 who confirmed that PSW #128 continued to work on the date of the incident, and the following day, which was during the home's investigation of the incident.

The inspector reviewed the home's policy titled Zero Tolerance of Abuse and Neglect.The policy stated that the staff member alleged to have caused the abuse or neglect was to be suspended with pay, pending further investigation, with the possibility of corrective action.

PSW #128 continued to perform their duties while the investigation was ongoing. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy to promote zero tolerance of abuse and neglect of resident #015 and all other residents is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was restrained by a physical device as described in paragraph 3 of subsection 30 only if the restraining of the resident was included in the resident's plan of care.

On November 4, 2015, Inspectors #603 and #580 observed resident #006 seated in a wheelchair with two different devices in place. Inspector #580 observed that the resident was unable to remove either device.

The inspector conducted an interview with PSW #105, RPN #111, and PSW #116 who all explained that resident #006 used both devices.

An interview was conducted with the Director of Nursing (DON) who indicated that when a resident has any device, these must be identified as either a restraint or a PASD, that a doctor's order may be required, and it should be documented. The DON further explained that staff get care direction from the electronic care plan and Kardex and that there is a hard copy of the Kardex available for backup that is reprinted with all updates.

The NCC explained to the inspector that resident #006's admitting nurse, RN #108 had not written care plan directions related to resident #006's different devices. The NCC stated that the home had "missed this".

PSW #116 explained to the inspector that resident #006's one device was a restraint. The staff further explained that the care plan directed staff to check on restraints, but was not able to find any care direction on the care plan related to resident #006's different devices.

RPN #111 confirmed that resident #006 was not able to remove two of the devices, and that therefore these were restraints, that care information about another device

used as a personal assistance services device needed to be in the care plan. RPN #111 explained to the inspector that care information needed to be in the care plan but that the home did not have information for this resident regarding restraints. Further, RPN #111 confirmed that there were no care directions for resident #006's other devices.

Inspector #580 reviewed the health care record for resident #006 and found no evidence of any documentation specific to the devices above, in the resident's care plan.

Inspector #580 reviewed the home's Minimal Restraint policy, which indicated that the home shall ensure that the resident's care plan indicates a measureable objective that explains the purpose of the use of the restraint or PASD and must also outline how the specific restraint or personal assistance service device is to be used and the timeframe for its use. [s. 31. (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 resident #006 may be only be restrained by a physical device as described in paragraph 3 of subsection 30 if the restraining of the resident is included in the resident's plan of care, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

According to a Critical Incident Report, a Respiratory-Influenza A outbreak was declared at the home by the Porcupine Public Health in February 2015. Fifteen residents and one staff were suspected cases and one resident was confirmed to have Influenza A.

The inspector reviewed the home's Critical Incident Report that was submitted four days after the outbreak was declared.

The Infection Control and Education Coordinator (ICEC) explained to the Inspector that she had just started the Infection Control and Education position and the NCC completed the Critical Incident report. The NCC confirmed to the inspector that the home was late in reporting the respiratory outbreak declared February 2015 and reported it four days later. [s. 107. (1)]

2. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

According to a Critical Incident Report, a respiratory disease outbreak was declared by the Porcupine Public Health in March 2015. Seven residents were experiencing cold symptoms.

Inspector #580 reviewed the home's Critical Incident Report submitted one day after the outbreak was declared.

The ICEC explained to the Inspector that she had just started the Infection Control and Education position and that therefore the NCC completed the Critical Incident report. The NCC confirmed to the inspector that the home was late in reporting the respiratory outbreak and reported it one day later. [s. 107. (1)]

3. The licensee has failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Inspector #603 reviewed a Critical Incident report, which was reported to the Director. The Critical Incident happened in July 2015, where resident #016 was found lying on the floor, on their back. The resident was complaining of pain and was transferred to the hospital.

The inspector reviewed the resident's progress notes which indicated that the home was notified by the hospital that the resident had two separate fractures and that the NCC was made aware of the resident's diagnosis.

The inspector interviewed the NCC who explained that they had not reported the incident for two days, because the home takes up to 72 hours to receive as much information as possible and then they will report. [s. 107. (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 the Director is immediately informed of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act and that the Director is informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital, to be implemented voluntarily.

WN #8: 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 were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

In an unlocked room, accessible from the Nurse Practitioner's (NP) office, Inspector #580 observed a large, moveable, one-lock medication cart that served as the home's Emergency Drug Box (EDB) which contained numerous bottles and/or vials of narcotic and controlled medication; the inspector also observed a vial of a controlled medication in an unlocked refrigerator in the same room. In addition, the inspector observed a controlled medication in unlocked, unsecured refrigerators in single-locked medication rooms in four Home Areas.

RN #108 and NP #124 confirmed to the inspector that the home kept the EDB in the Nurse Practitioner's office and that the EDB contained controlled and narcotic medications and that the NP's office require one key to open. RPN #111, RPN #112 and RPN #119 confirmed to the inspector that the medication refrigerators were unlocked and were located in the Home Area medication rooms which required one key to open.

The NCC explained to the inspector that the home has been trying to find a way to lock the refrigerators containing narcotic and controlled drugs, but has not been successful to-date. The NCC confirmed to the inspector that the home did not realize the requirement to store controlled substances in a separate, double-locked stationary cupboard in the locked area.

Inspector #580 reviewed the home's Drug Inventory Control – Storage of Drugs in the Medication Room policy, which indicated that narcotic and controlled drugs must be stored in a double locked cabinet in the medication cart or in the medication room. [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 the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #9: 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 were taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, and access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

In an unlocked room, accessible from the Nurse Practitioner's (NP) office, Inspector #580 observed a large, moveable, one-lock medication cart that served as the home's Emergency Drug Box (EDB) which contained numerous medications.

The NP and RN #108 confirmed to the inspector that the master key opens the NP office, that the EDB was single locked, that it contained numerous controlled substances, and that a vial of of a controlled substance was in the unlocked refrigerator in the unlocked room adjacent to the NP office.

The Administrator confirmed to the inspector that department supervisors including the maintenance supervisor, the housekeeping/laundry supervisor, and the dietitian, have the master keys that open the NP's office providing access to where the drugs are stored. Maintenance Staff #127 confirmed to the inspector that when he needed access to the NP's office for repair purposes, he would ask for the master key, be given it, that the key opened the NP's office, and that he would be unaccompanied when accessing the NP room.

Inspector #580 reviewed the home's Emergency Drug Box policy which indicated that only Nurse Managers/In-Charge RNs will have access to the EDB. The NCC confirmed to the inspector that the home's Emergency Drug Box policy is in use as a policy. [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, including all areas where drugs are stored shall be kept locked at all times, when not in use, and access to these areas shall be restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #10: 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:
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 training has been provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including the application of these physical devices, use of these physical devices, and potential dangers of these physical devices.

In November 2015, Inspector #603 interviewed the DON who explained that all staff caring for residents are trained on the home's Minimal Restraint Policy annually, however, they are not trained on the application of the physical devices, use of the physical devices, and the potential dangers of the physical devices. The last training for these issues were done "at least 3 years ago" by a third party. The DON explained that the home was aware that they lack this training for all staff who care for residents. [s. 221. (1) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that training is provided for all staff who apply physical devices or who monitor residents restrained by a physical device, including the application of these physical devices, use of these physical devices, and potential dangers of these physical devices, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the person, who had reasonable grounds to suspect that abuse had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

Inspector #612 reviewed Critical Incident (CI) Report alleging PSW #128 verbally abused resident #015. Resident #015 reported the incident in December 2014, to RPN #111 and the Director was not notified for one day, via the critical incident report completed by the NCC.

The inspector interviewed the NCC who confirmed that the home did not notify the Director immediately. [s. 24. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

In November 2015, Inspector #603 reviewed the resident's health care record and noted a weight loss of 4.5 kg in one month. In November 2015, the Registered Dietitian’s (RD) progress note indicated a 'Weight Warning' and the RD documented that the resident's intake at meals had been fair over the past quarter, with the resident refusing meals or eating only small portions. The RD’s progress note further explained that the resident was being offered supplements for poor meal intake and did take the supplements at times but refused on occasion and that as a result, the resident's weight had decreased.

The inspector reviewed the resident's care plan and noted no interventions to manage the resident's weight loss.

The inspector interviewed PSW #100 and RPN #101 who explained that the staff do not offer supplements to resident #005, nor is it in the plan of care to do so.

The inspector interviewed the RD who explained that there were no interventions related to manage the resident’s weight loss in the care plan. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

Issued on this 19 day of January 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : SARAH CHARETTE (612) - (A1)

Inspection No. / No de l'inspection : 2015_273580_0006 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 029405-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 19, 2016;(A1)

Licensee / Titulaire de permis : The Corporation of the City of Timmins
481 Melrose Blvd., TIMMINS, ON, P4N-5H3

LTC Home / Foyer de SLD : GOLDEN MANOR
481 MELROSE BOULEVARD, TIMMINS, ON, P4N-5H3

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : HEATHER BOZZER

To The Corporation of the City of Timmins, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that the plan of care sest out clear directions to staff and others who provide direct care specifically to resident #006 and other residents;

b) Ensure that resident #006 and any other resident who uses a device or devices, has a plan of care that includes care direction for the device or devices; and

c) Ensure that resident #006 and any other resident who is incontinent, has a plan of care that includes a focus, goals or interventions related to bladder or bowel continence.

Grounds / Motifs :

1. The licensee has failed to ensure that there is a written plan of care for resident #006 that sets out, clear directions to staff and others who provide direct care to the resident.

On November 4, 2015, Inspectors #603 and #580 observed resident #006 seated in a wheelchair with two different devices in use. The resident was unable to remove either device. On November 4, 2015, Inspector #603, observed resident #006 in bed with the bed rails in the up position.

The inspector conducted an interview with PSW #105, RPN #111 and PSW #116, who all explained that resident #006 used both devices as well as bed rails when in bed.

RPN #111 explained to the inspector that care information should be in the care plan and that there were no care directions for the two devices used by resident #006 or the bed rails.

The inspector conducted an interview with the Nursing Care Coordinator (NCC) who explained that resident #006's care plan did not have directions related to the resident's two devices or bed rails and that the home had "missed this".

Inspector #580 reviewed resident #006's health care record and found no evidence of any direction regarding the above noted devices. (580)

2. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provided direct care to resident #006.

Inspector #612 reviewed resident #006's care plan and was unable to find any focus, goals or interventions related to bladder or bowel continence.

The inspector interviewed PSW #116 who explained that resident #006 was continent of bladder and continent of bowel with assistance of two staff. The inspector interviewed RN #108 who explained that information related to resident's bladder and bowel continence should be found in the resident's care plan and confirmed that this information was not in resident #006's care plan. Therefore the care plan did not provide clear direction to staff regarding the resident's bladder and bowel continence.

The scope of this issue was isolated to one resident's plan of care not providing clear direction to staff providing care. However, there were three previous non-compliances issued in the last three years: inspections #2014_380593_0019 and #2013_139163_0032. They were directly related to LTCHA s. 6(1), the plan of care not providing clear direction to staff providing care. The severity was determined to be potential for actual harm to the health, safety and well-being of the resident. (612)

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

Jan 29, 2016

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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 shall:

a) Ensure that where bed rails are used, resident #006 and all other residents and their bed system are evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident and their bed system was evaluated in accordance with evidence-based practices or in accordance with prevailing practices to minimize risk to the resident.

On November 4, 2015, Inspector #603, observed resident #006 in bed with the bed rails in the up position.

In an interview conducted with Inspector #580, PSW #105, RPN #111 and PSW #116, confirmed that resident #006 had bed rails in the up position when in bed. RPN #111, further explained to the inspector that the assessment for resident #006's use of bed rails had been completed.

In an interview conducted with the inspector, RN #108 explained that resident #006's bed rail assessment was not completed.

The Nursing Care Coordinator stated to the inspector that the home had "missed this".

In November 2015, Inspector #603 interviewed the Director of Nursing (DON) who explained that the home does not have a formal process to evaluate the bed system, where bed rails are used. The DON explained that approximately one month ago, the home started to discuss this requirement and had purchased equipment to check for bed entrapment, however, there were no dedicated personnel or team to make these evaluations and as a result the residents and their bed systems have not been evaluated.

The scope of this issue was widespread. There was previous non-compliance issued unrelated to this. The severity was determined to be potential for actual harm to the health, safety and well-being of all residents of the home. (580)

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

Feb 29, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall:

a) Ensure that procedures are developed and implemented to ensure that all equipment and devices for resident monitoring are in a good state of repair and functioning correctly;

b) Ensure that the home's bed and chair alarm systems for resident #016 and a bed or chair alarm for any other resident who requires a bed or chair alarm, are maintained in a good state of repair and are functioning correctly;

c) Ensure on-going testing of the bed and chair alarm systems are completed, and that records of the testing and any interventions required to correct malfunctions, are maintained; and

d) Ensure training and retraining of staff include education of the home's policies and procedures related to maintaining the home in a safe condition and in a good state of repair.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair, excluding the residents' personal aids or equipment.

In November 2015, Inspector #603 reviewed a Critical Incident Report (CI) that was submitted to the Director. Resident #016 was found lying on their back, on the bathroom's floor and the resident's bed alarm was ringing faintly. Resident #016 sustained two fractures and required surgery.

Inspector reviewed the progress notes which indicated that the resident was found in their bathroom in front of the sink, lying on their back. The bed alarm was going off, but very faint and not heard by staff until they entered the room.

In November 2015, the inspector interviewed RPN #137 who was the staff member who found the resident on the bathroom floor. RPN #137 explained that after shift report, they walked out of the report room and they could hear a very faint and different alarm and thought the alarm came from a floor below the unit. RPN #137 walked by resident #016's room and heard the bed alarm ringing "very faintly" and observed that resident #016 was not in their bed. RPN #137 opened the resident's bathroom door and found the resident lying on their back on the floor. RPN #137 further explained that they thought perhaps the alarm's battery was low. After the incident, the staff asked management for a better alarm system for resident #016 and the alarm was subsequently replaced.

RPN #137 explained that the staff members are not expected to check for alarm reliability. The Nursing Care Coordinator (NCC) confirmed that the home has no process for checking alarm reliability. The NCC explained that the alarm in question was too low for staff to hear and for this reason, it was changed.

The scope of this issue was isolated to resident #016's reported critical incident and bed alarm. There was previous non-compliance issued unrelated to this. The severity was determined to be actual harm to the health, safety and well-being of this resident. (580)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

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

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

Jan 15, 2016

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee shall:

a) Ensure that the care set out in the plan of care is provided to residents #002, #003, #005, and all other residents as specified in their plan.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan.

Inspector #603 observed resident #002 sitting in their wheelchair in the dining room. The resident did not have a seat belt on. The inspector could not find any seat belt on the resident's wheelchair. The inspector interviewed PSW #136 who explained that the resident does not wear a seat belt while sitting in their wheelchair.

The inspector reviewed resident #002's care plan which indicated that the resident is to have a front clip seat belt in place when in wheelchair to maintain core stability and allow resident to self-propel wheelchair. (603)

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

Inspector #603 reviewed resident #003's health care record which indicated that the resident fell three times in September and October, 2015. The inspector reviewed the resident's care plan. The care plan had a focus for Risk for Falls and one of the interventions included was to check the resident every hour to ensure safety.

In November 2015, the inspector interviewed PSW #125 and RPN #126 who explained that the resident had fallen more "in the last while". PSW #125 explained that the resident walks with their walker and the staff were to watch the resident closely as they were prone to fall. The staff further indicated that they used to check and document on the resident every hour to ensure safety and that they no longer do this. (603)

3. The licensee has failed to ensure that care set out in the plan of care was provided to resident #005 as specified in the plan.

In November 2015, Inspector #603 reviewed resident #005's health care record and noted that the resident fell four times in 2015. According to the progress notes, the resident fell from their wheelchair which had a safety device; however, it did not function. When the resident was put back in the wheelchair, the staff had to apply a different safety device because the other device was not working.

The inspector reviewed the resident's care plan. The interventions included the safety devices, to ensure the devices were working properly every time resident was transferred into wheelchair or bed, and to check the resident every 30 minutes to ensure safety.

On November 5, 2015, Inspector #603 observed resident #005 sitting in their wheelchair, in the hallway, and with no safety device in place.

Inspector #603 interviewed PSW #110 who had positioned the resident in their wheelchair. They explained that they did not know the resident had a safety device, and it was not placed on the resident's chair.

The inspector observed PSW #110 retrieve the device from the resident's room and fasten it to resident's chair without checking to see if it worked. (603)

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

On November 4, 2015, Inspector #603 observed resident #005 sitting in their wheelchair. In resident #005's bedroom, Inspector #603 observed resident #005's bed was raised, both rails were engaged in the up position.

The inspector reviewed the resident's current care plan and Kardex report. Interventions under the focus for safety and fall prevention related to the resident trying to self-transfer without assistance, included that the bed rails were to be in a down position and safety checks were to be done every 30 minutes.

The inspector interviewed PSWs #100 and #102 who explained that resident #005 required both bed rails up (engaged) while in bed for safety and mobility, and confirmed that staff do not perform safety checks on resident #005, every 30 minutes as per the care plan.

The issue of care not being provided to residents as specified in the plan, was widespread. There was previous non-compliance issued unrelated to this. The severity was determined to be potential for actual harm to the health, safety and well-being of the residents of the home. (603)

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

Jan 29, 2016

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 19 day of January 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SARAH CHARETTE - (A1)

Service Area Office /
Bureau régional de services : Sudbury