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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l’inspection	Log #/ Registre no	Type of Inspection / Genre d’inspection
Nov 24, 2015;	2015_320612_0015 (A1)	018909-15	Resident Quality Inspection

Licensee/Titulaire de permis

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET P.O. BOX 190 HORNEPAYNE ON P0M 1Z0

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

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET P.O. BOX 190 HORNEPAYNE ON P0M 1Z0

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

SARAH CHARETTE (612) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Licensee has requested an extension to the compliance date for order #002 from December 31, 2015 to February 29, 2016.

Issued on this 24 day of November 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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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): August 5, 6, 11, 12, 13 and 14, 2015

During the course of the inspection, the inspector(s) spoke with The Chief Executive Officer (CEO), Long-Term Care (LTC) Manager, RAI Coordinator, Pharmacists, Activities Coordinator, Registered Staff, Personal Support Workers, Maintenance Manager, Residents and Family Members.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed numerous licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

10 WN(s)
5 VPC(s)
2 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. 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 the home's Falls Risk Assessment Policy was complied with.

On Aug 11, 2015 inspector #612 reviewed the home's internal Unusual Occurrence Report, related to a fall. The report indicated that resident #001 fell and that resident #001's substitute decision maker (SDM) was not notified of the fall.

Inspector #612 reviewed residents' most recent Morse Fall Scale (MFS) which was completed October 21, 2014.

Inspector #612 reviewed the home's policy titled Falls Risk Assessment, Operational Date Nov 8, 2009 and reviewed Oct 1, 2014. The policy stated that the resident's SDM will be advised as soon as possible after a resident falls. The policy also stated that if a resident falls, has a near fall or his/her condition improves/deteriorates a MFS will be repeated.

Inspector #612 spoke with S#101 who confirmed that the resident's SDM is to be notified and a MFS is to be repeated after a fall or with any change in a resident's condition. S#101 confirmed that resident #001's SDM was not notified of the fall as per the documentation and a MFS was not completed post fall. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's policy titled Restraints- Long-Term Care was complied with.

Inspector #612 reviewed resident #001's health care record. It was documented that on three dates, resident #001 was restrained with a specific device. The first instance resident #001 was exhibiting responsive behaviours, three staff restrained the resident to keep resident #001 and the other residents safe. Resident #001 was able to get out of the device.

The second instance resident #001 was exhibiting responsive behaviours and the staff applied the device. During the staff members' lunch and dinner times, resident #001 was brought to the nursing station so staff could supervise resident #001.

The third instance resident #001 was wandering the halls and exhibiting responsive behaivours, staff redirected resident multiple times. Staff placed resident in the restraint. An hour and a half later, it was documented in the residents' health care record that resident #001 got out of the restraint on their own.

Inspector reviewed resident #001's health care record and was unable to find an order from the physician for restraint or consent for the restraint from resident #001 or resident's SDM. Inspector spoke with S#101 who confirmed that no order was obtained from the physician and no consent was obtained from the resident or SDM to apply the restraint.

Inspector reviewed the home's policy titled Restraints- Long-Term Care. The policy stated that the home follows a least restraint policy. In the event of a resident being in immediate danger of injuring himself/herself or others and after other alternatives have been considered and found ineffective an RN may apply a physical restraint without a physician's order or client/SDM consent for an interim basis. A physician's order for the restraint will be obtained within 12 hours. As part of ongoing assessment, the RN and/or Physician discusses the restraint with the client, family or SDM, outlining the risks and benefits of using or not using restraints and explaining the reasons for the recommendations. The RN obtains written authorization for the use of restraints from the client or SDM. A physician's order for a restraint must be obtained and include the type of restraint to be used, its planned duration and the reasons for its use.

The consent from the resident/SDM and the physician's order were not obtained for the restraint for resident #001 as outlined in the home's Restraint- Long Term Care policy. [s. 8. (1) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff received, as a condition of continuing to have contact with residents, training in behaviour management, at times or at intervals provided for in the regulation.

Inspector #612 requested the training records related to the management of responsive behaviours. S# 101 provided the inspector with a binder which contained training for staff however no training related to responsive behaviours was found. S#101 reported they did not recall annual training on responsive behaviour management. S#101 confirmed, with the LTCH manager on the phone, that the home does not have a policy related to the management of responsive behaviours.

The Chief Executive Officer (CEO) confirmed that S#101 was the contact person while the Director of Care (DOC) was away.

On August 13, 2015, inspector interviewed S#101 and S#105 who recall having training and being sent to a course in the past, related to dementia, however, no annual training related to the management of responsive behaviours. S#113 stated that impromptu education will be provided when scenarios present themselves, staff will get together to review cases that may occur in the hospital, in the form of learning scenarios. S #113 confirmed that there was no formal 'class room' style education, they work as a team and have open discussions. [s. 76. (7) 3.]

2. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with resident, training in Continence Care and Bowel Management, at times or intervals provided for in the regulations.

The inspector spoke with registered S#102 about education and/or training that staff received who stated that sometimes the home will offer some seminars that are presented by out of town people.

Inspector #543 then inquired about training specifically related to programs required by the legislation; S#102 stated they sometimes have computer stuff to read and sign off but that they could not recall the last time such education was completed.

Inspector #543 and #612 spoke with registered S#113 regarding training provided to direct care staff related to mandatory programs, who stated that impromptu education will be provided when scenarios present themselves. S#113 stated that staff will get together and review cases that may occur in the hospital, in the form of a learning scenario. They also stated that because the hospital/LTCH is so small there is no formal “class room” style education, they work as a team and have open discussions.

On August 13, 2015; inspector #543 spoke with registered S#101 regarding training provided to direct care staff specifically related to Continence Care and they confirmed that the home does not provide annual training for such programs. The Chief Executive Officer (CEO) confirmed that S#101 was the contact person while the Director of Care (DOC) was away. [s. 76. (7) 6.]

3. The licensee has failed to ensure all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in Falls Prevention and Management at times or intervals provided for in the regulations.

The inspector spoke with registered S#102 about education and/or training that staff received. They stated that sometimes the home will offer some seminars that are presented by out of town people.

Inspector #543 then inquired about training specifically related to mandatory programs required by the legislation; S#102 stated they sometimes have computer stuff to read and sign off but that they could not recall the last time such education was provided.

Inspector #543 and #612 spoke with registered S#113 regarding training provided to

direct care staff related to mandatory programs. S#113 stated that impromptu education will be provided when scenarios present themselves. They stated that staff will get together and review cases that may occur in the hospital, in the form of a learning scenario. They also stated that because the hospital/LTCH is so small there is no formal "class room" style education, they work as a team and have open discussions.

On August 13, 2015, inspector #612 spoke with registered S#101 regarding training provided to direct care staff, specifically related to Falls Prevention and Management and they confirmed that the home does not provide annual training for Falls Prevention and Management. The Chief Executive Officer (CEO) confirmed that S#101 was the contact person while the Director of Care (DOC) was away. [s. 76. (7) 6.]

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 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. (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 failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #001.

Inspector #612 reviewed resident #001’s printed kardex and care plan which is kept at the nursing station.

Resident #001’s kardex, stated that resident required limited assistance with dressing and toilet use.

Inspector #612 reviewed resident #001’s printed care plan. Under the toileting focus the following intervention was listed:
- One person constant supervision and physical assist

Under the dressing focus the following interventions were listed:
- Provide intermittent supervision and assistance.
- Provide total assistance.

Inspector interviewed S#101, 102 and S#105 who confirmed that the printed kardex and care plan at the nurses' station are what they access for direction on the care that a resident requires. S# 101 and S# 105 stated that resident #001 requires extensive assistance from two staff for dressing and toileting. S#101 and S#105 confirmed that the plan of care is not clear to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

Inspector #612 reviewed resident #001’s printed kardex and care plan which are kept at the nursing station.
The following intervention was listed:
- Document resident's whereabouts hourly on wanderers' checklist.

Inspector interviewed S#101, S# 105 and S# 106 who confirmed that the home does not have a wanderers' checklist and they have not been documenting residents' whereabouts hourly. [s. 6. (7)]

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 #001's plan of care provides clear direction to staff and that the care set out in the plan of care is provided to resident #001, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

On August 5, 2015 inspector #612 conducted a tour of the home. Inspector entered the Long-Term Care (LTC) unit through the main entrance and discovered the door to be unlocked. Inspector observed that door #2 at the side of the building was unlocked and inspector was able to exit the building and access the parking lot of the home. Inspector also observed that the doors leading to the acute care side of the hospital were unlocked, which would permit residents to access other areas of the hospital and exit the entrance of the building to the parking lot.

Inspector #612 reviewed one internal unusual occurrence report, dated May 2, 2015 and four wander-guard failure reports dated June 1, 2015, June 5, 2015 and two from June 10, 2015. On each occasion, a resident, who had a wander-guard bracelet on, was able to exit the doors at the side of the building while the alarm was sounding and make their way to the parking lot.

Inspector #612 interviewed S#111 who confirmed that the system was overloaded which made it possible for the door to be opened even though the alarm was sounding.

Inspector #612 interviewed the Chief Executive Officier who confirmed that the main entrance door, door #2 and the doors leading to the acute care side are not locked as they are considered fire doors. The CEO stated that most residents are independent and come and go as they please. Some residents have a wander-guard bracelet on which activates the system to lock the doors when they are in close proximity to a door and prevents them from exiting. The front doors to the building are locked from the outside at 1600hrs however anyone can exit the building without a code, they are required to press the buzzer which rings at the nurses' station to get back in. [s. 9. (1) 1. i.]

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 doors leading to the outside of the home are kept locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Inspector #543 reviewed resident #002's health care record, and was unable to locate a continence assessment. The inspector identified in the nursing progress notes, that since June 2015, this resident had 22 notes related to their continence routine, whereby the resident was described as having an increase in requesting to be toileted.

On August 11, 2015 Inspectors #543 and #612 reviewed the binders that contained the home's policies and procedures. The inspectors were unable to locate any policy and/or program related to continence care. Inspector #543 spoke with the CEO regarding policies, procedures and programs, who stated that the binders that registered S#101 provided are the only binders that would contain policies and/or programs for the home. There would be no other location for such policies.

On August 12, 2015, Inspector #543 spoke with registered S#101 regarding the home's Continence Care Program. They stated that staff would track residents' urinary and bowel continence on "tick sheets" but the home does not have Continence Care Program and/or policy. S#101 consulted the LTCH manager regarding a continence care policy/program who confirmed there is none developed at this time. S#101 confirmed that there was no clinically appropriate assessment instrument for use in the home. [s. 51. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident that is incontinent is accessed using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are 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. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s responsive behaviour program is developed and implemented in accordance with evidence-based practices or, if there are none, prevailing practices.

Inspector #612 reviewed the binders provided by registered S#101 which contained all the home’s policies and procedures. The inspector was unable to locate any policies or procedures related to a Responsive Behaviours Program.

Inspector interviewed S#101 who consulted with the LTCH manager and confirmed that the home does not have a Responsive Behaviour Program or policy. [s. 53. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home develops and implements a responsive behaviour program in accordance with evidence-based practices or, if there are none, prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, 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. The licensee has failed to ensure that semi-annual meetings are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council.

Inspector #543 spoke with S#112 regarding whether or not a Family Council was established in the home. They confirmed that the home does not have a Family Council. S#112 stated that the home does not convene semi-annual meetings to advise family members of the rights to establish a Family Council. [s. 59. (7) (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 semi-annual meetings are convened to advise residents' families and persons of importance to residents of their right to establish a Family Council, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident was assessed and that when the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #612 reviewed an internal unusual occurrence form completed Aug 05, 2015. The report stated that resident #001 had a fallen. Resident #001 was able to get up independently by the time staff arrived.

Inspector #612 interviewed registered S#101 and asked if the home had a clinically appropriate assessment instrument specifically designed for falls. S#101 stated that after a fall, the home will complete an internal unusual occurrence report however that report is not specifically designed for falls, it is completed for a variety of incidents. The form is used for other incidents including but not limited to, alleged/actual abuse, missing person, unexpected death, transfer to hospital, etc.

The internal Unusual Occurrence Form was not a clinically appropriate assessment instrument specifically designed for falls. [s. 49. (2)]

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey was taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Inspector #544 and #612 interviewed S#112 who stated that they had conducted informal surveys with the residents in the past, focusing mostly on the activities offered in the home, however S#104 was responsible for the satisfaction survey.

Inspector #612 spoke with S#104 by telephone Aug 18, 2015. S#104 confirmed that this was the first year that the home was in the process of developing a satisfaction survey which measures satisfaction with the care, services, programs and goods provided at the home. S#104 stated that the survey was in draft form and had not been distributed to the resident/families. [s. 85. (1)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On Aug 5, 2015, inspector #612 observed the dining room during lunch service. Inspector observed S#109 and S#108 removing resident's dirty soup bowls and then provided residents with their lunches without performing hand hygiene. Inspector also observed that S#108 touched the garbage can and did not perform hand hygiene prior to touching a resident's clean plate with their food on it.

On Aug 12, 2015 inspector #612 observed the medication pass for resident #001 at 1630hrs. Inspector observed that S#106 came into contact with resident #002's while administering medications. S#106 did not perform hand hygiene prior to preparing resident #001's medication. S#106 then entered resident #001's room and sat beside resident #001 on their bed to administer their medication. S#106 did not perform hand hygiene after leaving resident #001's room and returning to the medication cart to prepare medications for the next resident.

Inspector #612 interviewed S#101, S# 105 and S#106 who confirmed that the home utilizes the four moments of hand hygiene, hand hygiene is to be completed before and after patient contact.

Inspector #612 requested the home's Infection Control Policy. Inspector was provided with two binders containing policies. One titled Nursing Policy and Procedure Manual and the other titled Infection Prevention and Control Guide. Inspector reviewed the home's Infection Control Policy, operational date June 17, 2011 and reviewed October 3, 2014. The policy stated that the nursing department will follow the most up to date Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practice Standards and that a hard copy of the most recent Best Practice Standards will be kept in the Infection Prevention and Control Guide binder. The home's policy outlines the four moments of hand hygiene. [s. 229. (4)]

Issued on this 24 day of November 2015 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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_320612_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 018909-15 (A1)

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

Report Date(s) / Date(s) du Rapport : Nov 24, 2015;(A1)

Licensee / Titulaire de permis :
HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET, P.O. BOX 190,
HORNEPAYNE, ON, P0M-1Z0

LTC Home / Foyer de SLD :
HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET, P.O. BOX 190,
HORNEPAYNE, ON, P0M-1Z0

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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 : Lisa Verrino

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home's Restraint policy and Falls Prevention Policy is complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Falls Risk Assessment Policy was complied with.

On Aug 11, 2015 inspector #612 reviewed the home's internal Unusual Occurrence Report, related to a fall. The report indicated that resident #001 fell and that resident #001's substitute decision maker (SDM) was not notified of the fall.

Inspector #612 reviewed residents' most recent Morse Fall Scale (MFS) which was completed October 21, 2014.

Inspector #612 reviewed the home’s policy titled Falls Risk Assessment, Operational Date Nov 8, 2009 and reviewed Oct 1, 2014. The policy stated that the resident’s SDM will be advised as soon as possible after a resident falls. The policy also stated that if a resident falls, has a near fall or his/her condition improves/deteriorates a MFS will be repeated.

Inspector #612 spoke with S#101 who confirmed that the resident's SDM is to be notified and a MFS is to be repeated after a fall or with any change in a resident’s condition. S#101 confirmed that resident #001's SDM was not notified of the fall as per the documentation and a MFS was not completed post fall. (612)

2. The licensee has failed to ensure that the home's policy titled Restraints- Long-Term Care was complied with.

Inspector #612 reviewed resident #001’s health care record. It was documented that on three dates, resident #001 was restrained with a specific device. The first instance resident #001 was exhibiting responsive behaviours, three staff restrained the resident to keep resident #001 and the other residents safe. Resident #001 was able to get out of the device.

The second instance resident #001 was exhibiting responsive behaviours and the staff applied the device. During the staff members' lunch and dinner times, resident #001 was brought to the nursing station so staff could supervise resident #001.

The third instance resident #001 was wandering the halls and exhibiting responsive

behaviours, staff redirected resident multiple times. Staff placed resident in the restraint. An hour and a half later, it was documented in the residents' health care record that resident #001 got out of the restraint on their own.

Inspector reviewed resident #001's health care record and was unable to find an order from the physician for restraint or consent for the restraint from resident #001 or resident's SDM. Inspector spoke with S#101 who confirmed that no order was obtained from the physician and no consent was obtained from the resident or SDM to apply the restraint.

Inspector reviewed the home's policy titled Restraints- Long-Term Care. The policy stated that the home follows a least restraint policy. In the event of a resident being in immediate danger of injuring himself/herself or others and after other alternatives have been considered and found ineffective an RN may apply a physical restraint without a physician's order or client/SDM consent for an interim basis. A physician's order for the restraint will be obtained within 12 hours. As part of ongoing assessment, the RN and/or Physician discusses the restraint with the client, family or SDM, outlining the risks and benefits of using or not using restraints and explaining the reasons for the recommendations. The RN obtains written authorization for the use of restraints from the client or SDM. A physician's order for a restraint must be obtained and include the type of restraint to be used, its planned duration and the reasons for its use.

The consent from the resident/SDM and the physician's order were not obtained for the restraint for resident #001 as outlined in the home's Restraint- Long Term Care policy.

The decision to issue this compliance order was based on the severity which indicates a potential for actual harm and the scope which was widespread as the policies affect all resident's in the home. (612)

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

Nov 26, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

(A1)
The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, c. 8, s. 76 (7).

The plan must include:

(1) A timeline for when all staff training (including those staff currently employed)
will be completed in the following areas:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations.

(2) The home s schedule for annual retraining on the above areas.

(3) A process to track completion of annual retraining.

(4) How the retraining will be provided (i.e. online learning, class room, etc).

(5) Process to update relevant policies to address annual retraining.

This plan must be faxed, to the attention of LTCHI Sarah Charette, at (705) 564-
3133. This plan is due on November 12, 2015 with a compliance date of February 29, 2016.

Grounds / Motifs :

1. The licensee has failed to ensure that all direct care staff received, as a condition of continuing to have contact with residents, training in behaviour management, at times or at intervals provided for in the regulation.

Inspector #612 requested the training records related to the management of responsive behaviours. S# 101 provided the inspector with a binder which contained training for staff however no training related to responsive behaviours was found. S#101 reported they did not recall annual training on responsive behaviour management. S#101 confirmed, with the LTCH manager on the phone, that the home does not have a policy related to the management of responsive behaviours.

The Chief Executive Officer (CEO) confirmed that S#101 was the contact person while the Director of Care (DOC) was away.

On August 13, 2015, inspector interviewed S#101 and S#105 who recall having training and being sent to a course in the past, related to dementia, however, no annual training related to the management of responsive behaviours. S#113 stated that impromptu education will be provided when scenarios present themselves, staff will get together to review cases that may occur in the hospital, in the form of learning scenarios. S #113 confirmed that there was no formal 'class room' style education, they work as a team and have open discussions. (612)

2. The licensee has failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with resident, training in Continence Care and Bowel Management, at times or intervals provided for in the regulations.

The inspector spoke with registered S#102 about education and/or training that staff received who stated that sometimes the home will offer some seminars that are presented by out of town people.

Inspector #543 then inquired about training specifically related to programs required by the legislation; S#102 stated they sometimes have computer stuff to read and sign off but that they could not recall the last time such education was completed.

Inspector #543 and #612 spoke with registered S#113 regarding training provided to direct care staff related to mandatory programs, who stated that impromptu education will be provided when scenarios present themselves. S#113 stated that staff will get together and review cases that may occur in the hospital, in the form of a learning scenario. They also stated that because the hospital/LTCH is so small there is no formal "class room" style education, they work as a team and have open discussions.

On August 13, 2015; inspector #543 spoke with registered S#101 regarding training provided to direct care staff specifically related to Continence Care and they confirmed that the home does not provide annual training for such programs. The Chief Executive Officer (CEO) confirmed that S#101 was the contact person while the Director of Care (DOC) was away. (612)

3. The licensee has failed to ensure all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in Falls Prevention and Management at times or intervals provided for in the regulations.

The inspector spoke with registered S#102 about education and/or training that staff received. They stated that sometimes the home will offer some seminars that are presented by out of town people.

Inspector #543 then inquired about training specifically related to mandatory programs required by the legislation; S#102 stated they sometimes have computer stuff to read and sign off but that they could not recall the last time such education was provided.

Inspector #543 and #612 spoke with registered S#113 regarding training provided to direct care staff related to mandatory programs. S#113 stated that impromptu education will be provided when scenarios present themselves. They stated that staff will get together and review cases that may occur in the hospital, in the form of a learning scenario. They also stated that because the hospital/LTCH is so small there is no formal “class room” style education, they work as a team and have open discussions.

On August 13, 2015, inspector #612 spoke with registered S#101 regarding training provided to direct care staff, specifically related to Falls Prevention and Management and they confirmed that the home does not provide annual training for Falls Prevention and Management. The Chief Executive Officer (CEO) confirmed that S#101 was the contact person while the Director of Care (DOC) was away.

The decision to issue this compliance order was based on the severity, potential for actual harm to residents' and the scope which is widespread as it is all staff that had not received the training. (612)

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

Feb 29, 2016(A1)

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

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

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 24 day of November 2015 (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