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
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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
Oct 06, 2014;	2014_250511_0010 (A2)	H-000439-14	Resident Quality Inspection

Licensee/Titulaire de permis

NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road, St. Catharines, ON, L2M-7Y2

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

INA GRAFTON-GAGE HOME
413 Linwell Road, St Catharines, ON, L2M-7Y2

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

ROBIN MACKIE (511) - (A2)

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): April 25, 28, 29, 30, 2014 and May 1, 2, 6 2014

This Resident Quality Inspection included inspection H-000443-14 related to a loss of nurse call/communication system. The Environmental Inspector will issue a report under separate cover.

During the course of the inspection, the inspector(s) spoke with The Chief Executive Officer (CEO), Director of Resident Care(DRC), Manager Food Services and Laundry, Manager of Environmental Services, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), Registered Dietician (RD), residents, families, activation staff and housekeeping/laundry staff

During the course of the inspection, the inspector(s) observed the provision of resident care, toured the home, reviewed relevant policies, procedures and resident clinical records, including Resident Assessment Instrument-Minimum Data Set (RAI-MDS) applicable and Resident Assessment Protocol (RAP).

The following Inspection Protocols were used during this inspection:

Admission and Discharge

Continence Care and Bowel Management

Dignity, Choice and Privacy

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Skin and Wound Care

Sufficient Staffing

Trust Accounts

Findings of Non-Compliance were found during this inspection.

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee did not ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

A review of the Registered Staffing Schedule for April 21, through May 4, 2014 identified a patterned absence of Registered Nurses (RN) that were filled by Registered Practical Nurses (RPN). During this time there were 28 shifts where there were no RN's present and on duty in the home. The DRC identified they did not have an RN for these regular scheduled shifts and these shifts were replaced by an RPN. The DRC confirmed they last recruited for RN's approximately 2 years ago and this has been an ongoing issue for the home which was identified as a previous non-compliance in the home's staffing plan in 2012. [s. 8. (3)]

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. 78. Information for residents, etc.

Specifically failed to comply with the following:

s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 78 (2)
(b) the long-term care home's mission statement; 2007, c. 8, s. 78 (2)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 78 (2)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 78 (2)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 78 (2)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 78 (2)
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained; 2007, c. 8, s. 78 (2)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 78 (2)
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home; 2007, c. 8, s. 78 (2)
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges; 2007, c. 8, s. 78 (2)
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge; 2007, c. 8, s. 78 (2)
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by

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Findings/Faits saillants :

1. The licensee did not ensure the admission package included at a minimum the followings items:

1. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
2. An explanation of the protections afforded by section 26 whistle-blowing protections related to retaliation;
3. An explanation of the duty under section 24 to make mandatory reports;
4. The written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
5. Notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
6. Information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations.

A review of the Long Term Care Home Licensee Confirmation Checklist-Admission Process, completed on April 25, 2014, identified required items that were not included in the home's Admission package. An Interview with the Administrator and a review of the resident Admission package, which included the Resident's Handbook Long Term Care, revised April 2014 and Admission/Annual Agreement Long Term, confirmed the information provided to a resident and to the substitute decision maker at the time the resident was admitted, did not comply with the requirements set out in s. 78.(2). [s. 78. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 did not ensure that, when the resident had fallen, the resident was assessed and, where 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.

Resident #025, whose MDS assessment indicated a falls risk, experienced a few falls in 2014. After one of the resident's falls, the resident complained of frequent severe pain. X-ray reports indicated no fracture. The resident's condition warranted a post fall assessment. No post fall assessment using an appropriate tool for the falls was completed. This information was confirmed by a review of the clinical records and by the DRC. [s. 49. (2)]

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. 52. Pain management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) Resident #025 complained of pain during an interview in 2014 and stated the pain was from two falls experienced in one month. The resident was observed to be exhibiting pain symptoms during the interview with wincing and facial grimacing noted. Review of the clinical records indicated the resident sustained falls in the same given month in 2014. A review of the progress notes indicated the resident had complained of pain after the falls and received, as needed,non-narcotic pain medication. The clinical records stated the resident stayed in their room for the evening and was complaining of severe pain and was crying out. The progress notes stated the resident was advised to lay in bed to stretch out and the resident's response to the medications and treatments given was that it was doing "no good". Progress notes confirmed the resident continued to complain of pain from the falls and indicated the pain was so bad that they were unable to remove their clothing. The nurse further documented that the resident seemed to be extremely anxious about the pain. The physiotherapy note confirmed several bruises on the resident. There were no pain assessments using a clinically appropriate assessment instrument during this time. Interview with the DRC confirmed the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose when the resident's pain was not relieved by initial interventions.(511)

B) In a specified month in 2014 resident #010 had expressed having unresolved pain in their shoulders and knees. The resident had multiple diagnosis that would indicate a condition of pain existed. In the following month in 2014, one of the resident's narcotic pain medication was discontinued. The resident continued to receive another narcotic for pain management. The resident's progress notes indicated that the resident complained of pain on several occasions throughout the month and on two occasions was found yelling due to the pain. The home's policy and procedure Number LTC-08-21-02 regarding Seventy-Two (72) Hour Assessment of Pain (revised on October 2011) indicated that "It shall be identified that a resident may be exhibiting signs and symptoms of pain. The following procedure shall be followed: a) document in the progress notes the initiation of the seventy-two (72) hour assessment form. Ensure that all information is stated on the form; b) utilize the Pain Management Assessment Form on every shift..." The form was not completed for pain following the discontinuation of one of the resident's pain medication. The home did not ensure that the resident's pain as noted above was assessed or documented according to a

clinically appropriate assessment instrument or according to the home's policy. Registered staff and the Director of Resident Care (DRC) confirmed that the 72 hour Assessment of Pain was not completed when the resident exhibited signs and symptoms of pain.(526) [s. 52. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Resident #008 reported to an inspector that they had reported to the home that they had witnessed a resident being treated roughly by a staff person. The DRC confirmed that the complaint had been reported to the home. According to progress notes, resident #026 had reported to the home in 2014 that money had been stolen from their room. There were no further notations of the complaint. According to the progress notes resident #032 reported to the home that jewelry was missing from the resident's room in 2013. The family also reported this to an inspector in stage one of this RQI. There were no further notations in the progress notes. When the DRC was asked to produce the complaint log, the DRC stated that the home kept no documented record of complaints other than what was documented in progress notes. [s. 101. (2)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that staff participated in the implementation of the infection prevention and control program.

A) On April 25, 2014 during dining service between 1145 and 1245 hours staff were observed to not wash their own hands between feeding residents and between clearing dirty dishes and handing out the second course of the meal. The home's infection control policy IC-02-13-01 dated July 2011 indicated that "Hand hygiene with an alcohol-based hand rub or with soap and water before and after physical contact with a resident or a contaminated environment" and policy number IC-02-13-04, regarding hand hygiene, stated "Hands must be cleaned with alcohol based hand rub or soap and water: a) before and after contact with a resident; b) before performing invasive procedures; c) before preparing, handling, serving or eating food...". The home did not ensure that staff implemented the infection control program.

B) The licensee did not ensure that residents were offered immunizations against tetanus, diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website. Upon inspection of resident health records, there were no indication that three (#002, #004, #008) of four residents had been offered immunizations against tetanus and diptheria. The DRC confirmed that residents were not routinely offered tetanus and diptheria immunizations in accordance with publicly funded immunization schedules. [s. 229. (4)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 261. Statements

Specifically failed to comply with the following:

s. 261. (1) Every licensee of a long-term care home shall, within 30 days after the end of each month, provide each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month. O. Reg. 79/10, s. 261 (1).

Findings/Faits saillants :

1. The licensee did not ensure, within 30 days after the end of each month, they provided each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month.

The Administrator confirmed that the monthly accommodation fees were paid through automatic pre-authorized withdrawals and residents did not receive a monthly statement as residents and or the resident's Power of Attorney could review their own monthly bank statements for itemized charges made within the month. [s. 261. (1)]

Additional Required Actions:

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

WN #8: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

In 2014 the nursing progress notes stated resident #017 attempted to self transfer and sustained a skin tear to the leg during the transfer. Interview with the family member confirmed the resident was transferring independently from the toilet when they struck their leg on the commode chair and sustained an injury. A review of the most recent

Resident Assessment Instrument-Minimum Data Set (RAI-MDS), section G, in a specified month in 2014, indicated the resident required extensive assistance and required two staff for physical assistance for toileting. The most recent plan of care in 2013, indicated the resident used a cane and required one person for physical assistance to walk to the bathroom for toileting. Two PSW staff interviewed stated the resident required one person to assist the resident to walk to the bathroom, did not use a cane and confirmed that the plan of care did not set out clear directions to staff and others who provided direct care to the resident. [s. 6. (1) (c)]

2. The licensee did not ensure that the plan of care was based on an assessment of the resident's needs and preferences.

A) Resident #012 expressed concern that staff had not assisted them, given them time or reminded them to perform oral care. The resident stated that their upper dentures were not brushed prior to putting them back in their mouth each morning and that their bottom teeth were not brushed either by themself or by staff. The resident stated that they required a reminder and some assistance to ensure that their oral care was adequately performed. On specific days in April and May, 2014 resident #012 confirmed that their oral care had not been performed and debris was observed in the resident's teeth during this time. The resident's RAI-MDS data as of February, 2014 indicated that the resident required extensive assistance from one staff with hygiene including grooming. The resident's most recent care plan that was last reviewed in November 2013 indicated that the resident required assistance with grooming, however would do oral care independently. In May, 2014 staff confirmed that they did not perform or assist the resident with oral care that day. The plan of care was not based on the assessment that the resident needed assistance with hygiene, including oral care, and was not based on the resident's needs and preferences.

B) Resident #009 was observed to have debris between their teeth and a foul breath odour between specific dates in April and May, 2014. The resident stated that they performed their own oral care. The resident's RAI-MDS dated March, 2014 indicated that the resident required extensive assistance from one person for hygiene including oral care. The resident's care plan dated January, 2014 indicated that the resident was able to perform their own oral care if staff set them up. Signage posted in the resident's bathroom indicated that staff were to set the resident up so that they could perform oral care independently. However, resident observation indicated the resident's teeth were soiled on specific dates between April and May, 2014. The plan of care was not based on the resident's assessment or the resident's needs and preferences. [s. 6. (2)]

3. Staff involved in the different aspects of care for resident #022 and #010 did not collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other in relation to skin integrity.

A) For resident #022, the June 10 and August 26, 2013, RAI-MDS coding and RAPs identified no pressure areas; some pressure areas in November, 2013; and more extensive pressure ulcers on the February, 2014 assessment. At the August, 2013 nutritional assessment the Registered Dietitian RD identified several pressure areas being treated and monitored by nursing staff. At the November, 2013 nutrition assessment the resident's skin was noted to be intact. At the February, 2014 nutritional assessment the RD noted multiple and extensive pressure areas on the resident's skin. The RAI-MDS coding and RAPs were not consistent between the nursing and Dietitian assessments.(107)

B) For resident #010, documentation on the RAI-MDS assessment, section M, skin and RAPs related to pressure ulcers for July and October, 2013, January, March, April, 2014 stated the resident's skin was intact with no history of resolved ulcers. Documentation on the RD RAPs and nutritional assessments identified open/pressure areas on the resident's skin. In October, 2013 the RD identified multiple areas of pressure ulcers; January and April 2014 multiple ares of pressure ulcers. Documentation was not consistent between the assessments completed by different disciplines. The RD stated that stage X and bruising were the same thing. However, the DRC reported that bruises were documented on the home's stage X monitoring form and were coded under bruising, not Stage X on the RAI-MDS assessments. [s. 6. (4) (a)]

4. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Resident #021's plan of care directed staff to put the bed in the lowest position after care was given as a safety strategy. A sign posted at the head of the bed alerted caregivers to this care plan intervention. In May, 2014 the resident was observed asleep in their bed on an air flow mattress with the bed elevated at approximately 80 cm from the floor. The PSW confirmed that someone had forgotten to lower the bed after care and lowered the bed when alerted. [s. 6. (7)]

5. The licensee did not ensure that the resident was reassessed and the plan of care

reviewed and revised when the resident's care needs changed.

A) In a specific month in 2014, resident #025 was observed to be experiencing pain as evidenced by facial grimacing and complaints of pain related to a few falls experienced in the same month in 2014. A review of the most recent written plan of care did not identify the resident's change in care needs as it related to ongoing pain sustained from the falls. The DRC confirmed that the resident's plan of care had not been revised when the resident's care needs changed.(511)

B) At a 2013 nutrition quarterly review, it was identified that resident #036's intake at meals had decreased, weight was declining and the resident was less than the stated desirable body weight range, documented pressure ulcers (an increase from previous quarter documentation), however, the plan of care was not revised in relation to the identified changes. Interventions were not in place to address the weight loss, skin areas, and declining intake. During interview, the resident stated they were eating less due to disliking the food. During interview, the RD stated interventions were not revised as the resident would not take supplements and alternative strategies were not documented.(107)

C) The RD increased the quantity of resident #039's nutritional supplement in a specific month in 2014 in relation to a reduction in food intake. The supplement was increased daily(increase of 120 kcals per day). During interview, the RD confirmed that a re-assessment of the resident's nutritional requirements for energy and protein were not completed in relation to the nutritional supplement. The RD stated the quantity of the nutritional supplement was based on outcome, not an assessment of the resident's requirements for energy and protein in relation to their intake. The resident had a significant weight loss for the following month in 2014. The RD confirmed that the resident's nutritional requirements were calculated on admission and were not revised with changes to the resident's nutritional status, weight or health condition.(107)

D) At a quarterly nutrition review in 2013, the RD identified there was a change to resident #022's skin integrity (documented as skin intact in March and June, 2013). A re-assessment of the resident's nutritional requirements in relation to increased needs for wound healing, and in relation to the resident's current intake and menu offered through the home, were not documented. During interview, the RD stated that nutritional requirements were calculated on admission and were not re-assessed when there were significant changes in health status or needs. The resident's plan of care was not revised in relation to the poor skin integrity. A nutritional quarterly

assessment in 2014, it was identified that the resident was not eating the supper meal for four days. Documentation did not reflect the reason for the poor intake and interventions on the resident's plan of care were not revised to prevent weight loss. (107)

E) According to documentation by the RD, resident #010 developed poor skin integrity as noted on the nutritional assessment in 2013. A re-assessment of the resident's nutritional requirements in relation to increased needs for wound healing, and in relation to the resident's current intake and menu offered through the home, were not documented. During an interview, the RD stated that the nutritional requirements were calculated on admission, were not re-assessed with changes in condition and the resident's plan of care was not revised.(107)

F) The licensee did not ensure that the plan of care set out clear direction regarding infection management and plan of care. In a specific month in 2014, resident #032 began to demonstrate signs and symptoms of respiratory tract infection including chest congestion, cough, and elevated temperature. The resident was placed on droplet isolation precautions. Resident #032's most recent care plan was reviewed in and did not provide information to staff regarding infection monitoring and care to be provided to the resident while in isolation. The DRC confirmed that the care plan was not reviewed and revised when the resident's care needs changed.(526) [s. 6. (10) (b)]

Additional Required Actions:

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

(A2)The following order(s) have been rescinded:CO# 008

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the following rights of residents were fully respected and promoted: Every resident had the right to be afforded privacy in treatment and in caring for his or her personal needs.

Interview with a family member, who wished not to be identified, stated resident's were not given privacy when the staff enter the resident's room without knocking. Resident #12 stated when their door was closed, the staff would knock but then proceed to enter the room without waiting to be acknowledged and felt this was not respecting their right to privacy. Staff were observed throughout April and May, 2014, on greater than 7 occasions, to enter residents' rooms without knocking or knocking on a closed door and proceeding without waiting for the residents' acknowledgment. Interview with the DRC confirmed the rights of residents were not fully respected and promoted when entering residents' rooms without knocking or waiting for resident acknowledgment. [s. 3. (1) 8.]

2. The licensee did not ensure that the following rights of residents were fully respected and promoted: Every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Two family members, who wished not to be identified, stated they heard other resident's personal health information when staff were overheard speaking in the hallways about resident care. In May, 2014 staff were observed to be speaking in a loud tone using resident names in the hallways. An interview with the wound care nurse confirmed the practice was to try and restrict discussing resident care concerns to resident rooms but that this did not always happen and wound care concerns were sometimes discussed in the hallway. Interview with the DRC confirmed that she was aware that staff discussed resident care in hallways and this does not ensure the resident's right to have their personal health information kept confidential in accordance with the Act. [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs and have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The nutrition care and hydration program did not include the development and implementation of policies and procedures relating to hydration.

A policy was not in place, that directed staff in the monitoring, identification and interventions, for staff to take when poor hydration occurred. The DRC and registered nursing staff were unable to provide a policy that directed nursing staff in relation to hydration management. The Registered Dietitian confirmed a policy and formalized procedure was not in place for the nutrition care and hydration program that included the development and implementation of policies and procedures relating to hydration. [s. 68. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the development and implementation of policies and procedures relating to hydration, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that all staff received training annually related to the home's policy to promote zero tolerance of abuse and neglect of residents.

In an interview the DRC stated that abuse training was not done annually with staff; it was done with new staff on orientation and then every two years with performance appraisals. [s. 76. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff received training annually related to the home's policy to promote zero tolerance of abuse and neglect of residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 80. Regulated documents for resident

Specifically failed to comply with the following:

s. 80. (1) Every licensee of a long-term care home shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, unless,
(a) the regulated document complies with all the requirements of the regulations; and 2007, c. 8, s. 80. (1).
(b) the compliance has been certified by a lawyer. 2007, c. 8, s. 80. (1).

Findings/Faits saillants :

1. The licensee did not ensure that a regulated document presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident: (a) the regulated document complied with all the requirements of the regulations; and (b) the compliance had been certified by a lawyer.

Interview with the Administrator confirmed the regulated documents, specifically the Admission Agreement for Long Term Care presented for signature to residents had not been certified by a lawyer. [s. 80. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a regulated document presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident: (a) the regulated document will comply with all the requirements of the regulations; and (b) the compliance will be certified by a lawyer, to be implemented voluntarily.

WN #13: 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 did not ensure that, (a) drugs were stored in an area or a medication cart, (ii) that was secured and locked.

A) On April 30, 2014 at 0820, the medication cart was observed in the hallway unattended with the drawers unlocked and easily opened. The medication nurse was in a resident room out of sight of the unlocked cart.(146)

B) On April 25, 2014 at 1630, the medication cart was observed in the hallway unattended with the drawers unlocked and easily opened. The medication nurse was in a resident room out of sight of the unlocked cart.(511) [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs, stored in an area or a medication cart, will be secured and locked, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with LTCHA, 2007, s. 9. Restorative care

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that there is an organized interdisciplinary program with a restorative care philosophy that,
(a) promotes and maximizes independence; and 2007, c. 8, s. 9 (1).
(b) where relevant to the resident's assessed care needs, includes, but is not limited to, physiotherapy and other therapy services which may be either arranged or provided by the licensee. 2007, c. 8, s. 9 (1).

Findings/Faits saillants :

1. The licensee did not ensure that there was an interdisciplinary restorative care program that promoted and maximized independence, and included but was not limited to, physiotherapy and other therapy services, where relevant, which may be arranged or provided by the licensee.

Restorative care planning and provision was not seen in clinical records inspected. The home's policy and procedures for restorative care were under revision. The DRC confirmed that the home did not have a restorative care program. [s. 9. (1)]

WN #15: 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 did not ensure that a person who had reasonable ground to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director including abuse of a resident by anyone or neglect by the licensee or staff that resulted in harm or risk of harm.

In 2013 staff heard screaming coming from resident #003's room indicating a resident was choking another them. Staff entered the room and observed resident #018 standing beside resident #003. Resident #003 was visibly upset, crying and yelling. Resident #003 stated that they didn't think they would sleep that night as they were afraid that resident #018 might enter and try to kill them. The DRC confirmed that the incident occurred and was not reported to the Director according to legislative requirements. [s. 24. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident received fingernail care including cutting of fingernails.

A) Between April and May, 2014 resident #010 was observed to have long fingernails with black debris beneath fingernails and old chipped polish. The resident stated that they didn't like their fingernails to be as long as they were and they should be trimmed during her bath. The resident stated that they didn't like the chipped nail polish on their fingernails. The bath schedule and staff confirmed that the resident had two baths between specific dates in April and May, 2014. Resident #010's RAI-MDS indicated that the resident needed extensive assistance with hygiene from at least two staff members. The DRC confirmed that nail care was a standard care activity each bath day. The resident did not receive fingernail care between specific dates in April and May, 2014.

B) Between April and May, 2014 resident #009 was observed to have long fingernails with black debris beneath fingernails and old chipped polish. On a day in May, 2014 the resident's nails were unevenly shortened with the nail polish partially removed and black debris noted beneath fingernails. The resident stated that they didn't like their fingernails to be long or to be trimmed so jaggedly as they were. The bath schedule and staff confirmed that the resident had two baths between April and May, 2014. Resident #009's RAI-MDS indicated that the resident needed extensive assistance with hygiene from at least one staff member. The DRC confirmed that nail care was a standard care activity each bath day. The resident did not receive adequate fingernail care between April and May, 2014. [s. 35. (2)]

WN #17: 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 did not ensure where there was 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 (b) convene semi-annual meetings to advise such persons of the right to establish a Family Council.

Interview with the DRC confirmed the home does not have a a Family Council but holds quarterly meetings and invites family and residents to attend. A review of the minutes over the previous six months did not identify information that advised the attendees of their rights to establish a family council. Interview with two family members confirmed they attend a meeting held by the DRC quarterly but were unaware of the right to establish an independent Family Council. The DRC confirmed she schedules and directs the meetings and has not discussed, at these meeting, the importance of the resident's rights to establish a Family Council. [s. 59. (7) (a)]

WN #18: 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 did not ensure that resident #039 was assessed using an interdisciplinary approach with action taken and outcomes evaluated for a significant weight loss in one month from February to March 2014.

Documentation did not reflect an assessment of the significant weight loss and actions were not taken in relation to the significant weight loss. The RD had increased the resident's nutritional supplement in February, however, no interventions or assessment of the significant weight change occurred in March. The resident's weight was reviewed by the RD in April, 2014 noting a weight gain, however, no assessment of the March weight by the nursing staff or RD occurred for the weight loss in March, 2014. Interview with the RD confirmed an interdisciplinary assessment of the weight loss did not occur in March and confirmed that nursing was not routinely involved in the assessment of significant weight changes. [s. 69. 1.]

WN #19: 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 did not 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.

The DRC was unable to provide documentation and confirmed in an interview that a survey, to the resident and families to measure the satisfaction with the home, was not completed in 2013. [s. 85. (1)]

Issued on this 6 day of October 2014 (A2)

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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
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Télécopieur: (905) 546-8255

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : ROBIN MACKIE (511) - (A2)

Inspection No. / No de l'inspection : 2014_250511_0010 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : H-000439-14 (A2)

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

Report Date(s) / Date(s) du Rapport : Oct 06, 2014;(A2)

Licensee / Titulaire de permis : NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH
413 Linwell Road, St. Catharines, ON, L2M-7Y2

LTC Home / Foyer de SLD : INA GRAFTON-GAGE HOME
413 Linwell Road, St Catharines, ON, L2M-7Y2

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 : PATRICK O'NEILL

To NIAGARA INA GRAFTON GAGE HOME OF THE UNITED CHURCH, 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. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

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

Grounds / Motifs :

1. The licensee did not ensure that at least one Registered Nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations .

A review of the Registered Staffing Schedule for April 21, through May 4, 2014 identified a patterned absence of Registered Nurses (RN) that were filled by Registered Practical Nurses (RPN). During this time there were 28 shifts where there were no RN's present and on duty in the home. The DRC identified they did not have an RN for these regular scheduled shifts and these shifts were replaced by an RPN. The DRC confirmed they last recruited for RN's approximately 2 years ago and this has been an ongoing issue for the home which was identified as a previous non-compliance in the home's staffing plan in 2012. (511)

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

Sep 01, 2014

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 78. (2) The package of information shall include, at a minimum,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;

(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) an explanation of the duty under section 24 to make mandatory reports;
(e) the long-term care home's procedure for initiating complaints to the licensee;
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
(g) notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
(h) the name and telephone number of the licensee;
(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;
(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;
(k) information about what is paid for by funding under this Act or the Local Health System Integration Act, 2006 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;
(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;
(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;
(n) a disclosure of any non-arm's length relationships that exist between the licensee and other providers who may offer care, services, programs or goods to residents;
(o) information about the Residents' Council, including any information that may be provided by the Residents' Council for inclusion in the package;
(p) information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations;
(q) an explanation of the protections afforded by section 26; and
(r) any other information provided for in the regulations. 2007, c. 8, s. 78 (2)

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 :

The licensee shall ensure the package of information provided to a resident and to the substitute decision maker at the time the resident is admitted shall include information provided for in the regulation s. 78. (2)

Grounds / Motifs :

1. The licensee did not ensure the admission package included at a minimum the followings items:

1. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
2. An explanation of the protections afforded by section 26 whistle-blowing protections related to retaliation;
3. An explanation of the duty under section 24 to make mandatory reports;
4. The written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints;
5. Notification of the long-term care home's policy to minimize the restraining of residents and how a copy of the policy can be obtained;
6. Information about the Family Council, if any, including any information that may be provided by the Family Council for inclusion in the package, or, if there is no Family Council, any information provided for in the regulations.

A review of the Long Term Care Home Licensee Confirmation Checklist-Admission Process, completed on April 25, 2014, identified required items that were not included in the home's admission package. An Interview with the Administrator and a review of the resident Admission package, which included the Resident's Handbook Long Term Care, revised April 2014 and Admission/Annual Agreement Long Term, confirmed the information provided to a resident and to the substitute decision maker at the time the resident is admitted did not comply with the requirements set out in s.78.(2). (511)

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

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

Aug 31, 2014

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. 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).

Order / Ordre :

The licensee 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.

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

Grounds / Motifs :

1. The licensee did not ensure that, when the resident had fallen, the resident was assessed and, where 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.

Resident #025, whose MDS assessment indicated a falls risk, experienced a few falls in 2014. After one of the resident's falls, the resident complained of frequent severe pain. X-ray reports indicated no fracture. The resident's condition warranted a post fall assessment. No post fall assessment using an appropriate tool for the falls was completed. This information was confirmed by a review of the clinical records and by the DRC. [s. 49. (2)] (146)

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

Aug 31, 2014

Order # /
Ordre no : 004

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

Pursuant to / Aux termes de :

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

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 :

The licensee shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. The licensee did not ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) Resident #025 complained of pain during an interview in 2014 and stated the pain was from two falls experienced in one month. The resident was observed to be exhibiting pain symptoms during the interview with wincing and facial grimacing noted. Review of the clinical records indicated the resident sustained falls in the same given month in 2014. A review of the progress notes indicated the resident had complained of pain after the falls and received, as needed,non-narcotic pain medication. The clinical records stated the resident had stayed in their room for an evening and was complaining of severe pain and was crying out. The progress notes stated the resident was advised to lay in bed to stretch out and the resident's response to the medications and treatments given was that it was doing "no good". Progress notes confirmed the resident continued to complain of pain from the falls and indicated the pain was so bad that they were unable to remove their clothing. The nurse further documented that the resident seemed to be extremely anxious about the pain. The physiotherapy note confirmed several bruises on the resident. There were no pain assessments using a clinically appropriate assessment instrument during this time. Interview with the DRC confirmed the resident was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose when the resident's pain was not relieved by initial interventions. (511)

B) In a specified month in 2014 resident #010 had expressed having unresolved pain in their shoulders and knees. The resident had multiple diagnosis that would indicate a condition of pain existed. In the following month in 2014 one of the resident's narcotic pain medication was discontinued. The resident continued to receive another narcotic for pain management. The resident's progress notes indicated that the resident complained of pain on several occasions, throughout a specific month,

and on two occasions was found yelling due to the pain. The home's policy and procedure Number LTC-08-21-02 regarding Seventy-Two (72) Hour Assessment of Pain (revised on October 2011) indicated that "It shall be identified that a resident may be exhibiting signs and symptoms of pain. The following procedure shall be followed: a) document in the progress notes the initiation of the seventy-two (72) hour assessment form. Ensure that all information is stated on the form; b) utilize the Pain Management Assessment Form on every shift..." The form was not completed for pain following the discontinuation of one of the resident's pain medication. The home did not ensure that the resident's pain as noted above was assessed or documented according to a clinically appropriate assessment instrument or according to the home's policy. Registered staff and the Director of Resident Care (DRC) confirmed that the 72 hour Assessment of Pain was not completed when the resident exhibited signs and symptoms of pain.(526) [s. 52. (2)] (526)

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

Aug 31, 2014

Order # /
Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee shall ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

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

Grounds / Motifs :

(A1)
1. The licensee did not ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A) Resident #008 reported to an inspector that she had reported to the home that she had witnessed a resident being treated roughly by a staff person. The DRC confirmed that the complaint had been reported to the home. According to progress notes, resident #026 had reported to the home on April 5, 2014 that money had been stolen from his room. There were no further notations of the complaint. According to the progress notes resident #032 reported to the home that three diamond rings were missing from the resident s room on December 22, 2013. The family also reported this to an inspector in stage one of this RQI. There were no further notations in the progress notes. When the DRC was asked to produce the complaint log, the DRC stated that the home kept no documented record of complaints other than what was documented in progress notes. (146)

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

Sep 30, 2014(A1)

Order # /
Ordre no : 006

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

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. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Order / Ordre :

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

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

Grounds / Motifs :

1. The licensee did not ensure that residents were offered immunizations against tetanus, diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Upon inspection of resident health records, there were no indication that three (#002, #004, #008) of four residents had been offered immunizations against tetanus and diptheria. The DRC confirmed that residents were not routinely offered tetanus and diptheria immunizations in accordance with publicly funded immunization schedules. (526)

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

Aug 31, 2014

Order # /
Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 261. (1) Every licensee of a long-term care home shall, within 30 days after the end of each month, provide each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month. O. Reg. 79/10, s. 261 (1).

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 :

The licensee shall ensure, within 30 days after the end of each month, they provide each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month.

Grounds / Motifs :

1. The licensee did not ensure, within 30 days after the end of each month, they provided each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, with an itemized statement of the charges made to the resident within the month.

The Administrator confirmed that the monthly accommodation fees were paid through automatic pre-authorized withdrawals and residents did not receive a monthly statement as residents and or the resident's Power of Attorney could review their own monthly bank statements for itemized charges made within the month. (511)

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

Aug 31, 2014

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

(A2)
The following Order has been rescinded:

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident’s care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

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 6 day of October 2014 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : ROBIN MACKIE - (A2)

Service Area Office /
Bureau régional de services : Hamilton