Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 20, 2015	2014_325568_0028	L-001555-14	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
574 Northcliffe Avenue DUNDAS ON L9H 7L9

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

ST JOSEPH'S HEALTH CENTRE, GUELPH
100 WESTMOUNT ROAD GUELPH ON N1H 5H8

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

DOROTHY GINTHER (568), NUZHAT UDDIN (532), SHERRI GROULX (519)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 19, 20, 21, 24, 25, 26, 27, 28, December 1, 2, 2014

Completed a follow-up inspection on CO 001 L-001392-14

During the course of the inspection, the inspector(s) spoke with the Director of Care, Assistant Director of Care, Environmental Services Manager, Environmental Services Supervisor, 7 Registered Nurses, 9 Registered Practical Nurses, 14 Personal Support Workers, 3 Housekeeping Aides, 1 Administrative Assistant, RAI Coordinator, Resident Council representative, Family Council representative, Residents and Families.

The Inspector also conducted a tour of all resident areas and common areas; observed residents and care provided to them, observed meal service, medication passes, medication storage areas; reviewed health care records and plans of care for identified residents; reviewed policies and procedures of the home, minutes of meetings and observed the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_202165_0026	519

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.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care identified significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained.

a) Resident # 001 was observed on November 20, 2014 , during Stage 1 of the Resident Quality Inspection (RQI) to have three physical devices applied. The resident was unable to mobilize or to release any of the devices. Resident # 001 was observed again on November 25, 2014 and November 26, 2014 sitting in their wheelchair with the same physical devices applied. Interview with a Registered staff revealed that front line care staff believe the devices are being applied to prevent the Resident from falling.

Resident # 001's clinical record included a form entitled, Long-Term Care - Personal Assistance Safety Device (PASD) Information for Consent and Physician Order. Under the section "Nursing Device and Restraint Assessment" dated June 20, 2014 completed by registered staff, "No" is documented for the following statements:
-Imminent risk of self harm persists

-Imminent risk of harm to others persists
-Nursing alternatives have been trialed and were unsuccessful
-OT referral for appropriate device.
The section of the form entitled Physician's Order indicates that the three devices are PASD's and are all to be applied and evaluated according to SJHCG policy. The orders are written and signed June 23, 2014,

The completed Monthly Resident PASD Assessment dated November 22, 2014 indicates that the Resident is using three physical devices which have been classified as a PASD. The assessment, completed by a registered staff, deemed the devices still appropriate based on the current Resident Assessment Instrument (RAI) outcome scores and a fall in the last quarter. It was documented that the plan was to continue with current treatment (changes were not applicable). There were no other restraint or PASD assessments found in the residents' clinical record.(519)

b) Resident #002 was observed on November 21, 2014, November 25, 2014 and November 26, 2014 with one physical device applied. Staff indicated that they have been instructed to apply the physical device when the resident is up. Staff also shared that the resident is unable to remove the device on their own.

Resident #002's clinical record contained a completed "Long Term Care- PASD Information for Consent and Physician Order" form. The section entitled, Nursing Device and Restraint Assessment, dated June 30, 2014 and completed by registered staff documented "No" to the following statements:
Imminent risk of self harm persists
Imminent risk of harm to others persists
Nursing alternatives have been trialed and were unsuccessful
OT referral for appropriate device.
The section of the form entitled Physician's Order indicates that the PASD be applied and evaluated according to SJHCG policy. [redacted].

The completed Monthly Resident PASD Assessment dated November 19, 2014 indicates that the physical device is still appropriate based on the most recent RAI outcome scores. [redacted] The plan of care did not contain any other restraint or PASD assessments for resident #002.

Record review failed to reveal any assessments for resident #001 and resident #002 that

identified risk to the resident or others prior to the application of physical devices; and there is no indication that alternatives were considered or trialed prior to the application of the devices.

The Lead for the Restraints Program indicated that the physical devices being used for resident #001 and #002 were classified as PASD's based on the residents' RAI outcome scores, medical and falls history. The plan of care for both resident #001 and #002 did not indicate how the devices would meet the definition of a PASD; which according to the Long Term Care Homes Act (LTCHA)2007, c.8, s.33(2) is a device that is used to assist a person with a routine activity of living. Resident #001 and #002 were [redacted] unable to release the physical devices that had been applied.

The Director of Care confirmed that prior to resident #001 and resident #002 having the physical devices applied the plan of care had not satisfied the following:
1. Identification that the resident or others were at imminent risk of suffering serious bodily harm.
2. Alternatives were considered or trialed prior to the application of the devices.
3. The method of restraining was least restrictive in light of the resident's physical and mental condition and personal history.
4. Physician's orders pertain to a PASD but the plan of care does not satisfy the definition of a PASD. [s. 31. (2) 1.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the policy to minimize restraining of residents is complied with.

Resident # 001 was observed on several occasions during Stage 1 of the Resident Quality Inspection (RQI) with three physical devices applied.

The home's policy Clinical 002-3 entitled Least Restraint Process, dated as revised August 2013 revealed that all clients who are restrained shall have the following documented in his/her chart: what alternatives were considered and why those alternatives were inappropriate. The Policy indicates that in the event that alternative treatment interventions have not been successful in eliminating/reducing risk factors, the least restrictive type of restraint will be used. The need for a physical restraint or PASD to be used ongoing should be reviewed and documented quarterly by the physician/NP.

Appendix A of the policy states that the benefits and risks of restraint usage will be reviewed including: Possible client safety (Risk of falls may actually increase with the use of restraints), Possible client security (Emotional reactions such as anger, fear, humiliation, resistance, increased agitation), Enhancement of functioning (functional decline, loss of appetite, entrapment risks). Appendix B of the policy entitled, Preventative Interventions/Possible Alternatives to Restraint Use lists suggested alternatives for the problems of falls, sliding, wandering, dementia, confusion, agitation, and aggression. The policy also lists under Appendix C "SJHC Least Restraint Decision Tree".

The document "Long-Term Care - PASD Information for Consent and Physician Order" for resident #001 [redacted] signed by a registered staff, indicates that no nursing alternatives were trialed. Review of the health care record did not reveal documentation to support Appendix B of the policy which relates to preventative interventions and possible alternatives to restraint use. The Lead for the restraints program confirmed that there was no assessment for Resident #001 related to Appendix A and B of the policy.

The licensee failed to ensure that that the policy entitled Least Restraint Process was complied with when resident # 001 had three physical devices applied without alternatives trialed and documented. (519)

2. The Home's policy Clinical-002-1 entitled Least Restraints indicates that a client may be restrained by physical, chemical or environmental restraint if the following provisions are included in the plan of care:

1. There is a significant risk that the client or another person would suffer serious bodily harm if the client were not restrained.
2. Alternatives to restraining the client have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk.
3. The method of restraining is reasonable , in light of the client's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk.
4. A physician or Nurse Practitioner (NP) has ordered the restraint.
5. The restraining of the client has been consented to by the client or, if the client is incapable, a SDM of the client with authority to give consent.

Record review revealed that consent was received from resident #002's Power of Attorney for the application of a physical device. Interview with two Personal Support Workers revealed that resident #002 was to have this device applied when up. The staff indicated that resident #002 has used this device for as long as they could remember; at least a year. Documentation indicates that the physical device had been applied in March 2014. The physician's order for the device to be applied was signed and dated June 30, 2014.

There was no evidence during a review of the clinical record that resident #002 or another person would suffer serious bodily harm if the physical device were not applied and that alternatives to the use of the device had been considered.

Registered staff confirmed that they had not followed the Home's Policy Clinical -002-01 related to the assessment of risk to the resident and other persons, alternatives to the application of the device, and ensuring there was a written order for the restraint prior to it's application.n(568) [s. 29. (1) (b)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to be protected from abuse.

[redacted] The resident began to cry after the incident occurred.

The licensee failed to ensure every resident is protected from abuse. [s. 3. (1) 2.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #007 had a fall and sustained an injury which required further evaluation. A doctor's order was written which included referral to the Physiotherapist (PT) for an assessment.

During observation of resident #007's room it was noted there was no mention of the resident's injury on the paper Kardex posted on the wall. Record review revealed that there was no reference to resident #007's injury.

On November 27, 2014 Registered Staff confirmed that the care plan and the Kardex in resident #007's room should have been updated to reflect the injury and any changes to care. Registered staff confirmed that the Personal Support Workers (PSWs) refer to the wall Kardex and the care plan to direct their individualized care of the resident. The staff member also indicated that when the resident is assessed by the Physiotherapist, and a decision is made about specific interventions for care staff to provide, this should be included in the plan of care. [s. 6. (10) (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 the residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Record review indicated that resident #006 used bed rails to assist with bed mobility and transfers.

During the inspection resident #006 was observed to have [redacted] bed rails in the "up" position. A Personal Support Worker reported that they don't put the rails down as the resident requires them at all times.

The Program Lead for Restraints confirmed that beds were not assessed and bed systems were not evaluated in accordance with evidence-based practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are non, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

On two occasions during the inspection resident #001 was observed sitting in their wheelchair in the middle of the room. The call bell was tied to the side rail of the bed which the resident could not reach.

Registered staff indicated that it is the home's expectation that the call bell is clipped to the resident or within reach, especially when they are unable to mobilize, so the resident has access to their call bell at all times. The staff member confirmed that resident #001 could not access their call bell when it was tied to the side of the bed. [s. 17. (1) (a)]

2. The following was observed for Resident #003:
During stage 1 of the inspection the resident was observed sitting in a chair on the left side of the bed by the window. The call bell was observed under and behind the bed on the floor.
During stage 2 of the inspection the resident was observed sitting in their chair on the left side of the bed. The call bell cord was attached to the side rail on the right side of bed and the call bell was hanging down on the floor.

The Registered staff untangled the call bell and moved it closer to the resident on the left side of the bed. She confirmed that the call bell should be easily seen, accessed, and used by the resident. [s. 17. (1) (a)]

3. On two occasions during the inspection resident #002 was observed sitting in their room in a wheelchair. The call bell was wrapped around the lowered bed rail on the opposite side of the bed and not within reach of the resident.

The care plan for resident #002 indicates that comfort rounds will be done every 30 minutes to ensure that the resident has what they need within reach, like the call bell. Care staff confirmed that resident #002 should have the call bell accessible when up in the wheelchair.

Staff confirmed that on November 21, 2014 and November 25, 2014 Resident #002's call bell was not easily seen or accessible by the resident. [s. 17. (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 the home has a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #7: 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 a 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 is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Resident #005 was identified as being frequently incontinent of bowel, 2 to 3 times a week, on the Minimum Data Set (MDS) Assessment [redacted]. The MDS Assessment [redacted] indicates that Resident #005 is usually incontinent of bowel, less than weekly.

Staff interview revealed that Resident #005 will usually let staff know when they need to have a bowel movement but there are situations when the resident is incontinent.

Staff interview with the lead for the Continence Program revealed that the Home has not yet developed an assessment for bowel continence. The staff member confirmed that resident #005 did not receive an assessment that includes the identification of causal factors, patterns and potential to restore function and is conducted using a clinically appropriate assessment instrument designed specifically for bowel incontinence. [s. 51. (2) (a)]

2. Quarterly review assessment [redacted] indicated that resident #008 was occasionally incontinent of bowel and the bowel elimination pattern indicated that the resident was constipated.
Record review and interview with Registered staff revealed that resident #008 was receiving a number of medications and treatments for constipation.

Review of the clinical record revealed that there was no bowel continence assessment completed for the resident. The Program Lead for Continence Care confirmed that residents who were incontinent of bowel were not assessed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident require. [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 a 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 is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council.

During an interview with a representative of the Resident Council, they indicated that they could not recall if the meal and snack times had been discussed at the Resident Council meetings.

Meeting minutes from November 2014 indicated that the Food Service Manager inquired if the snack and meal times had ever been approved by Resident Council and informed the residents that they would be sending a proposal. In an interview on December 02, 2014 an Assistant to the Resident Council confirmed that the dining and snack service including a review of the meal and snack times were not approved by the Resident Council. [s. 73. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the dining and snack service included a review of the meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #9: 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 staff participate in the implementation of the infection prevention and control program.

On November 19, 2014, during the initial tour of the home, it was noted in several shower and tub rooms that personal care items for residents were not labeled with their names.

Registered staff confirmed that resident's personal hygiene equipment was to be individually labelled and stored separately. [s. 229. (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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, and/or cleaning of dentures.

Resident #008 was observed on two occasions during the inspection to have stained teeth with debris between them. On three occasions the following was observed: Toothbrush and toothpaste were sitting in the kidney basin (K-basin) in the bathroom in the same location and the toothbrush bristles were dry and stuck to the K-basin.

The resident did not receive oral care to maintain the integrity of the oral tissue, including mouth care in the morning. [s. 34. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident has their personal items, including personal aids cleaned as required.

On November 21, 2014, November 26, 2014 and December 2, 2014 resident #002 and #004 were observed to have food debris and stains on the cushion and frame of their wheelchairs.

Interview with the Environmental Services Supervisor revealed that the housekeeping department is responsible for cleaning the wheelchairs on a monthly basis. In between, it is the responsibility of the nursing staff to spot clean the chairs if there is a spill, and for more extensive cleaning issues they can contact the housekeeping department. The Home's procedure HK-028-2 for Wheelchair Cleaning indicates that wheelchairs will be cleaned as part of the evening assignment. Some chairs may require weekly cleaning and some monthly.

The Environmental Services Supervisor indicated that wheelchairs on two home areas had not been cleaned in November because of staff shortages. Registered staff indicated that it is nursing's responsibility to clean any spills or stains on resident's wheelchairs in between the monthly cleanings and confirmed that resident #002 and #004's wheelchairs were not cleaned as required. [s. 37. (1) (b)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart,
i. that is used exclusively for drugs and drug-related supplies,

[redacted]

During the medication room observation on second floor, it was noted that in the fridge that was used to store insulins, suppositories, and eye drops, food items were also present.

The Director of Care indicated that the creamers, butter, and tartar sauce should not be in the fridge that contains medications. The Director of Care confirmed that the fridge was to be used exclusively for drugs and drug-related supplies and food items should not have placed inside. [s. 129. (1) (a)]

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Issued on this 22nd day of January, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DOROTHY GINTHER (568), NUZHAT UDDIN (532), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2014_325568_0028
Log No. / Registre no:	L-001555-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 20, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 574 Northcliffe Avenue, DUNDAS, ON, L9H-7L9
LTC Home / Foyer de SLD :	ST JOSEPH'S HEALTH CENTRE, GUELPH 100 WESTMOUNT ROAD, GUELPH, ON, N1H-5H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARIANNE WALKER

To ST. JOSEPH'S HEALTH SYSTEM, 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.O. 2007, c.8, s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Order / Ordre :

The licensee shall ensure that the restraining of resident #001 and #002 and any other resident by a physical device may be included in the resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious
bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered and tried where appropriate.
3. The method of restraining is reasonable, in light of the resident's physical and mental
condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in 1.
4. A physician, registered nurse in the extended class or or other person provided for in
the regulations has ordered or approved the restraining.

Grounds / Motifs :

1. a) On November 21, 2014, November 25, 2014 and November 26, 2014 resident #002 was observed with one physical device applied. Staff indicated that they have been instructed to apply the device when the Resident is up. Staff also shared that the resident is not able to release the seat belt on her own.

Resident #002's clinical record contained a completed Long Term Care - Personal Assistance Services Device(PASD) Information for Consent and Physician Order form. The section entitled, Nursing Device and Restraint Assessment, dated June 30, 2014 and completed by registered staff documented "No" to the following statements:
Imminent risk of self harm
Imminent risk of harm to others persists
Nursing alternatives have been trialed and were successful
OT referral for appropriate device.
The section of the form entitled Physician's Order indicates that the PASD be applied and evaluated according to SJHCG policy. [redacted]

The completed Monthly Resident PASD Assessment dated November 19, 2014 indicates that the physical device is still appropriate based on the most recent Resident Assessment Instrument (RAI) outcome scores. [redacted]

[redacted]

The plan of care did not contain any other restraint or PASD assessments for resident #002.

b) Resident # 001 was observed on November 20, 2014 , during Stage 1 of the Resident Quality Inspection (RQI) to have three physical devices applied. The resident was unable to mobilize or to release any of the devices. Resident #001 was observed again on November 25, 2014 and November 26, 2014 sitting in their wheelchair with the same physical devices applied. Interview with a Registered staff revealed that front line care staff believe the devices are being applied to prevent Resident #001 from falling.

Resident # 001's clinical record included [redacted] forms entitled, Long-Term Care - PASD Information for Consent and Physician Order. Under the section "Nursing Device and Restraint Assessment", each dated June 20, 2014 and completed by Registered Staff, "No" is documented for the following statements:
-Imminent risk of self harm persists
-Imminent risk of harm to others persists
-Nursing alternatives have been trialed and were unsuccessful
-OT referral for appropriate device.
The section of the form entitled Physician's Order indicates that the three devices are PASD's and are all to be applied and evaluated according to SJHCG policy. The orders were written and signed June 23, 2014.

The completed Monthly Resident PASD Assessment dated November 22, 2014 indicates that the Resident is using three physical devices that have been classified as a PASD. The assessment, completed by a Registered Staff, deemed the devices still appropriate based on the current Resident Assessment Indicators (RAI) outcome scores and a fall in the last quarter. It was documented that the plan was to continue with current treatment (changes were not applicable). There were no other restraint or PASD assessments found on the Resident's clinical record. (519)

Record review failed to reveal any assessments for Resident #001 and Resident #002 that identified risk to the resident or others prior to the application of the physical devices; and there was no indication that alternatives were considered or trialed prior to the application of the devices.

The Lead for the Restraints Program indicated that the physical devices being

used for Resident #001 and #002 were classified as PASD's based on the residents' RAI outcome scores, medical and falls history. The plan of care for both Resident #001 and #002 did not indicate how the devices would meet the definition of a PASD; which according to the Long Term Care Home's Act, 2007, c.8, s.33(2) is a device that is used to assist a person with a routine activity of living. Resident # 001 and #002 were [redacted] unable to release the physical devices that had been applied.

The Director of Care confirmed that prior to Resident #001 and #002 having the physical devices applied the plan of care had not satisfied the following:
1. Identification that the resident or others were at imminent risk of suffering serious bodily harm.
2. Alternatives were considered or trialed prior to the application of the devices.
3. The method of restraining was least restrictive in light of the resident's physical and mental condition and personal history.
4. Physician's orders pertain to a PASD but plan of care does not satisfy the definition of a PASD. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Order / Ordre :

The licensee shall ensure that the written policy to minimize the restraining of residents is complied with.

Grounds / Motifs :

1. The Home's Policy Clinical-002-1 entitled Least Restraints, dated as revised August 2013, indicates that a client may be restrained by physical, chemical or environmental restraint if the following provisions are included in the plan of care:
1. There is a significant risk that the client or another person would suffer serious bodily harm if the client were not restrained.
2. Alternatives to restraining the client have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk.
3. The method of restraining is reasonable , in light of the client's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk.
4. A physician or Nurse Practitioner (NP) has ordered the restraint.
5. The restraining of the client has been consented to by the client or, if the client is incapable, a SDM of the client with authority to give consent.

Record review revealed that consent was received from resident #002's Power of Attorney for the application of a physical device. Interview with two Personal Support Workers revealed that resident #002 was to have this device applied when up. The staff indicated that resident #002 has used this device for as long

as they could remember; at least a year. Documentation indicates that the physical device was applied in March 2014. The physician's order for the seat belt to be applied was signed and dated June 30, 2014.

There was no evidence during a review of the clinical record that resident #002 or another person would suffer serious bodily harm if the physical device were not applied and that alternatives to the use of the device had been considered.

Registered staff confirmed that they had not followed the Home's Policy Clinical - 002-01 related to the assessment of risk to the Resident and other persons, alternatives to the application of the device, and ensuring there was a written order for the physical device prior to it's application. (568)
(568)

2. Resident # 001 was observed on several occasions during stage 1 of the Resident Quality Inspection (RQI) with three physical devices applied.

The home's policy Clinical - 002-3 entitled least Restraint Process, dated as revised August 2013, revealed that all clients who are restrained shall have the following documented in his/her chart: what alternatives were considered and why those alternatives were inappropriate. The Policy indicates that in the event that alternative treatment interventions have not been successful in eliminating/reducing risk factors, the least restrictive type of restraint will be used. The need for a physical restraint or PASD to be used ongoing should be reviewed and documented quarterly by the physician/NP.

Appendix A of the same policy states that the benefits and risks of restraint usage should be reviewed including: Possible client safety (risk of falls may actually increase with the use of restraints), Possible client security (emotional reactions such as anger, fear, humiliation, resistance, increased agitation), Enhancement of functioning (functional decline, loss of appetite, entrapment risks). Appendix B of the policy entitled, Preventative Interventions/Possible Alternatives to Restraint Use it lists suggested alternatives for the problems of falls, sliding, wandering, dementia, confusion, agitation, and aggression.
The policy also lists under Appendix C "SJHC Least Restraint Decision Tree".

The document "Long-Term Care - PASD Information for Consent and Physician Order" for resident #001 [redacted] signed by a Registered staff, indicates that no nursing alternatives to restraints have been trialed and were

unsuccessful. Review of the health care record did not reveal documentation to support Appendix B of the policy which relates to the preventative interventions and possible alternatives to restraint use. The Lead for the Restraints program confirmed that there was no assessment for Resident #001 covering Appendix A and B of the policy.

The licensee failed to ensure that that the policy of "Least Restraint" was complied with when Resident # 001 had three restraint devices applied without alternatives trialed and documented. (519)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 20th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Dorothy Ginther

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