Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 21, 2015	2015_226192_0060	027948-15	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

DEBORA SAVILLE (192), CAROLYN MCLEOD (614), DOROTHY GINTHER (568), MEREDITH MCQUADE (629), SHARON PERRY (155), 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): October 21, 22, 23, 26, 27, 28, 29, 30, November 2, 3, 4 and 5, 2015.

This Resident Quality Inspection (RQI) was done concurrently with Complaint 021444-15 related to IL-40021-LO.
Critical Incident Inspections 009643-15, 011687-15, 013129-15, 028399-15 and 010019-15 are included in this RQI report.
Follow-up Inspection 016124-15 Compliance Order #001 related to medication policies and Follow-up Inspection 015656 Compliance Orders #002 related to the use of restraints are also included in this RQI report.
Follow-up Inspection 015656-15, Compliance Order #001 was not inspected as part of this RQI.

During the course of the inspection, the inspector(s) spoke with residents and family members, the Vice President of Clinical Services/Chief Nursing Executive, Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, the Resident Assessment Instrument (RAI)Coordinator, Environmental Services Aides, Business Office Administration, Manager of Environmental Services, Clinical Lead Recreation Therapy, Manger Rehabilitation and Outpatient Services and a Recreation Aide.

The inspectors toured the home, observed meal service, food preparation, medication administration, medication storage areas, recreation activities, reviewed relevant clinical records, reviewed relevant policies and procedures, schedules, the provision of resident care, resident-staff interactions, posting of required information and observed general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
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
Recreation and Social Activities
Resident Charges
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **19 WN(s)**
- **14 VPC(s)**
- **5 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 114. (3)	CO #001	2015_171155_0009	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.

Resident #006 was noted to use a specified device.

Review of the Resident Device Assessment for resident #006, indicated that resident #006 used the specified device. The section on the assessment where it indicated the risk to injury to self and risk of injury to others was blank.

The Long Term Care-Device Information for Consent and Physician Order, under nursing device assessment indicated N/A (staff confirmed N/A means not applicable) for significant risk of self harm and significant risk of harm to others.

Interview with staff revealed that resident #006 had the device to prevent the resident from falling.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the plan of care for resident #006 did not identify significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. [s. 31. (2) 1.]

2. Resident #030 was observed to have specified devices.

Review of the Resident Device Assessment for resident #030, indicated that resident #030 used the specified devices. The section on the assessment where it indicated the risk of injury to self and the risk of injury to others was blank.

The Long Term Care-Device Information for Consent and Physician Order, under nursing device assessment indicates N/A (staff confirmed N/A means not applicable) for significant risk of self harm and significant risk of harm to others.

Interview with staff revealed that resident #030 used the devices to prevent the resident from falling.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the plan of care for resident #030 did not identify significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. [s. 31. (2) 1.]

3. Resident #001 was observed in 2015, with multiple devices in use.

The plan of care for resident #001 failed to include the use of all of the devices observed, when reviewed.

Interview with a Registered Practical Nurse (RPN)- Device Program Lead confirmed that use of assistive devices were not included in resident #001's plan of care. The RPN confirmed that under tasks in Point Click Care staff were instructed what devices to apply and the frequency of checks required for each device. The RPN confirmed that a specified device could not be removed by the resident and was a restraint.

Review of the Resident Device Assessments identified use of a device related to a risk of falls but failed to identify that the resident or another person would be at significant risk if the resident were not restrained.

Interview with an RPN on the home area identified that assessment of risk to the resident

or risk to others would be completed by the Occupational Therapist (OT) when applying the device. Interview with the Manager Rehabilitation and Outpatient Services identified that when the OT received a referral related to application of a Restraint/Personal Assistive Services Device (PASD) the OT was assessing for the appropriate device with the understanding that the nursing department had already determined that a device was required due to risk to the resident or others.

The licensee 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. [s. 31. (2) 1.]

4. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

Resident #006 was noted to use a specified device. Review of the Resident Device Assessment for resident #006, indicated that resident #006 used the specified device. The section on the assessment where it indicated alternatives trialed indicated tools used to assess the resident but did not include the alternatives considered, and tried, that had not been effective in addressing the risk.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the restraint plan of care for resident #006 did not include alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk. [s. 31. (2) 2.]

5. Resident #030 was noted to use specified devices. Review of the Resident Device Assessment for resident #030, indicated that resident #030 used the specified devices. The section on the assessment where it indicated alternatives trialed, indicated tools used to assess the resident but did not include the alternatives considered, and tried, but that had not been effective in addressing the risk.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the restraint plan of care for resident #030 did not include alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. [s. 31. (2) 2.]

6. Resident #001 was found to attempt to self ambulate and a referral to Occupational Therapy related to use of a specified device was initiated in 2013. An assessment was conducted and a specified device was applied to the residents wheelchair, for

reassessment in one month.

Record review identified that when the device was applied, the resident became verbally aggressive requesting that the device be removed and indicating the device was causing discomfort. An area of redness was identified which was identified to be from the device.

A progress note completed by the Occupation Therapist indicated a a specified device was in place and was difficult for staff to open. There was no further reference to the device in documentation reviewed.

On a specified date it was identified in a physician/nurse practitioners note that the resident had pain and swelling in relation to use of the specified device.

The device, which restrained the resident, remained in place throughout the resident's admission with no indication of alternatives to the device documented as having been trialed.

Review of assessments conducted using the Resident Device Assessment (v2) indicated that the device remained in use. The most recent assessment, indicated that alternatives to restraining used included responsive behaviour interventions, physiotherapy/occupational therapy involvement, medication review, involvement of recreation programming and pain assessment.

Interview with the Director of Care confirmed that the identified alternatives on the Resident Device Assessment (v2) were assessments and not alternative interventions. Interview with the Clinical Lead for Recreation Therapy confirmed that when Responsive Behaviour and Recreation Programming interventions are initiated the restraint remains in place and are therefore not alternatives to restraining.

The plan of care identified under application of a device that nursing alternatives had been trialed and were unsuccessful but did not identify what nursing alternatives had been trialed or why those alternatives were ineffective.

The licensee failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. [s. 31. (2) 2.]

7. The licensee has failed to ensure that the restraint plan of care included the method of

restraining that was reasonable, in light of the resident's physical and mental condition; personal history; and was the least restrictive method, that would be effective, to address the risk.

Record review and observation revealed that resident #006 used a specified device. Resident #006 was not able to release the device. Record review revealed that on a specified date resident #006 was heard yelling in their room. The Personal Support Worker went to check the resident and found resident #006 on the floor with the device still in place.

Resident #006 was seen by Occupational Therapy as they had received a referral that stated the resident had a fall related to use of a specified device. Please access wheelchair. The wheel chair was assessed.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that in light of the resident's personal history restraints currently in use may be adding additional risk for resident #006 and may not have been the least restrictive method of restraint, that would be effective to address the resident's risk. [s. 31. (2) 3.]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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 ensuring that the restraint plan of care includes the method of restraining that is reasonable, in light of the resident's physical and mental condition; personal history; and is the least restrictive method, that would be effective, to address the risk, to be implemented voluntarily.

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. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents complied with such requirements as may be provided for in the regulations.

Regulation 109 states that the licensee shall ensure that the home's written policy under section 29 of the Act deals with:

(b)(ii) addressing the duties and responsibilities of the staff, including who had the authority to apply or release a physical device.

c) restraining under the common law duty pursuant to subsection 36(1) of the Act when immediate action was necessary to prevent serious bodily harm to the person or others.

d) the types of physical devices permitted to be used.

e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASD's as set out in section 33 of the Act was to be obtained and documented.

f) alternatives to the use of physical devices, including how those alternatives are planned, developed and implemented, using an interdisciplinary approach.

g) how the use of restraining in the home would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and the Regulation.

The home's policy titled Least Restraint/Device Policy, policy number Clinical-002-1 dated as reviewed October 2015, and the process titled Least Restraint/Device Process, process number Clinical-002-3 dated as reviewed October 2015, failed to address; the duties and responsibilities of the staff, including who had the authority to apply or release a physical restraint, restraining under common law duty pursuant to subsection 36(1) of the Act when immediate action was necessary to prevent serious bodily harm to the person or others, the types of physical devices permitted to be used, how consent to the

use of physical devices as set out in section 31 of the Act and the use of PASD's as set out in section 33 of the Act was to be obtained and documented, alternatives to the use of physical devices, including how those alternatives are planned, developed and implemented, using an interdisciplinary approach and how the use of restraining would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and Regulation

Interview with the Director of Care confirmed that the home's policy and procedure failed to include each of the above items.

The licensee failed to ensure that the home's written policy to minimize the restraining of residents complied with the requirements provided for in the Regulation. [s. 29. (2)]

Additional Required Actions:

CO # - 003 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. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week:

In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week.

St. Joseph's Health Centre has 144 + 96 Long-Term Care beds, in addition there were Complex Continuing Care and Rehabilitation beds, a day surgery and outpatient clinics.

Interview with the designated Administrator clarified that their role was as Vice President of Clinical Services, Chief Nursing Executive.

The Vice President of Clinical Services, Chief Nursing Executive identified they were responsible for all clinical services within the St. Joseph's Health Centre and all clinical managers report to them.

The Vice President of Clinical Services, Chief Nursing Executive confirmed that their responsibilities included Long-Term Care (LTC), Complex Continuing Care, Rehabilitation, Outpatient Clinics and Local Health Integration Network (LHIN) wide programs.

The Vice President of Clinical Services, Chief Nursing Executive confirmed their work week was 37.5 hours and that 70% of their time was spent on LTC.

The Vice President of Clinical Services, Chief Nursing Executive confirmed that staff of the home would go to the Director of Care (DOC) with concerns related to LTC.

The Vice President of Clinical Services, Chief Nursing Executive did indicate that the new President (May 2015) would have a role in LTC – indicating that the role of Administrator for Long-Term Care was a shared role.

During interview with the DOC it was identified that the Vice President of Clinical Services, Chief Nursing Executive had no hands-on responsibility for LTC. The DOC also confirmed that the workload of the Vice President of Clinical Services, Chief Nursing Executive had a broad scope and that the focus was not solely on LTC.

The licensee failed to ensure that the home's Administrator worked regularly in that position, on site at the home, for at least 35 hours per week. [s. 212. (1) 3.]

Additional Required Actions:

CO # - 004 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,
(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).
(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).
(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that a member of the registered nursing staff could permit a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if:

(a) The staff member had been trained by a member of the registered nursing staff in the administration of topicals

(b) The member of the registered nursing staff who was permitting the administration was satisfied that the staff member could safely administer the topical; and

(c) The staff member who administered the topical did so under the supervision of the member of the registered nursing staff

During an interview with the Director of Care, it was stated that Personal Support Workers (PSWs) had been applying topical creams to residents under their care.

She stated that the PSWs were expected to review the education on how to complete this task through the Medisystem Portal. She then confirmed that the home did not have a formal way of knowing if PSW's had completed this education as the Registered Staff do not supervise the PSWs applying the creams, or sign off on a form declaring they are competent to complete the task independently. The Registered Staff sign the treatment record that the creams had been applied.

The DOC stated that they would soon be implementing a Learning Management System in the home that would track the educational activity of all of the direct care staff but that was not in effect as of October 30, 2015. [s. 131. (4)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the rights of residents are fully respected and promoted:

1. Every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

Resident #003 reported to Inspector #155 that a staff member, when getting resident #003 up from their bed to the chair, had been rough and that they felt that they were being rushed. Resident #003 stated that they felt afraid of the staff member and were fearful that the staff's actions could cause them injury. Resident #003 described that when other staff get them up from bed to chair, they were gentle.

The licensee failed to ensure that resident #003 had their right to be treated with courtesy and respect, in a way that fully recognized the resident's individuality and respected the resident's dignity, respected and promoted. [s. 3. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that every residents right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

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

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 plan of care set out clear directions to staff and others who provide direct care to the resident.

The plan of care for resident #011 indicated under risk of falls that the resident used a specified device, the call bell was to be accessible, the resident was on the home's toileting routine and that a concave surface was to be used. Under transfers the plan of care indicated that resident #001 required assistance from one person, constant guidance.

During observation in the resident's room signage indicated that the resident required a specified intervention to prevent falls. The identified intervention was not in place during the inspectors observation.

A Personal Support Worker (PSW) confirmed that they were unaware of the posted

directions. The identified intervention was put in place by the PSW.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident when the plan of care and the posted signage provided variable directions to staff. [s. 6. (1) (c)]

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

Resident #064 had a history of physical altercations with co-residents. According to the progress notes, on a specified date an altercation between resident #064 and resident #065 resulted in resident #065 sustaining an injury.

On review of the care plan, it was identified that resident #064 was to have a sign on their door.

Observation of resident #064's room, identified that there was no sign on the door.

Interview with a Personal Support Worker (PSW), confirmed that the sign was in the care plan to be on the door but it was not on the door.

Interview with the Behavioural Supports Ontario Registered Practical Nurse, confirmed that the sign was in the care plan but not on the door.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when no sign was present on resident #064's door. (519) [s. 6. (7)]

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

A critical incident submitted to the Ministry of Health described an incident in which Resident #051 had been provided assistance by two Personal Support Workers. The resident was transferred using a specified lift. According to the report the two staff members became distracted with other residents and left Resident #051 in their room using a specified device. Another Personal Support Worker went into the resident's room and found Resident #051 using the specified device while still in the lift. The Personal Support Worker immediately reported to the Team Leader who completed a head to toe

skin assessment and notified the Director of Care.

The plan of care for Resident #051 indicated that the resident required two persons for constant supervision/physical assistance with lift and specified sling for transfers and for toileting.

Staff interview with two Personal Support Workers on Resident #051's home area revealed that resident's that use a specified lift must have two staff present for the transfer. In the case of transfers onto the toilet or commode one staff member must remain with the resident at all times. The staff indicated that on their unit it was particularly important to remain with the resident as they were often unpredictable. The staff shared that the level of supervision required when using specified lifts was reviewed during ongoing education provided by the home, as well as during staff meetings.

During an interview with the Assistant Director of Care (ADOC) they stated that staff were to follow the resident's care plan for direction related to transfers and toileting. The ADOC confirmed that staff did not provide constant supervision for resident #051. (568) [s. 6. (7)]

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

The plan of care under Ulceration or Interference with structural integrity of layers of the skin for resident #008 indicated specific rest routines and an intervention staff were to use per the resident's request.

The resident's room was observed on October 27, 2015, at 1315 hours. The resident was not in the room. The device for staff to use to complete the requested intervention was not available in the room.

Interview with the Registered Practical Nurse and a Personal Support Worker confirmed that the intervention staff were to use per the resident's request was no longer used for the resident.

The Registered Practical Nurse confirmed that the plan of care had not been updated with changes in the residents care needs. [s. 6. (10) (b)]

5. The plan of care for resident #001 under Impaired Skin Integrity indicated that a specific product was to be applied to both legs daily and was to be removed at bedtime.

Observation of the resident failed to identify the use of the specified product to both legs.

Interview with the Registered Practical Nurse identified that the application of the specified product had been discontinued some time prior as it was no longer necessary. The RPN confirmed that the plan of care had not been updated to reflect this change in the residents care needs.

Review of the medical record identified that the physician had discontinued the use of the specified product and the Treatment Administration Record was updated to stop the treatment. It was noted that when the Three Month Medication Reviews were signed by the physician two specified months in 2015, the use of the specified product was continued.

The licensee failed to ensure that when resident #001 was reassessed by the physician and the care needs changed, the plan of care was reviewed and revised. [s. 6. (10) (b)]

6. The Critical Incident Report C564-000010-15 indicated that Resident #050 had a fall and was transferred to hospital for further assessment. The resident was found to have an injury which required surgical intervention. The resident was re-admitted to the home.

Clinical records for Resident #050 revealed that the resident was a high risk to fall based on the most recent Falls Risk Assessment Tool (FRAT). The resident's plan of care related to falls risk identified that the resident was to have a specified device when they were in bed. The plan of care specific to toileting indicated that the resident required two person total assistance for the entire process.

Resident #050 was observed lying in bed with two quarter bed rails raised. A device was observed hooked to the bed but it did not appear to be activated. When asked, the resident stated that the device was only set at night. The resident was then observed to transfer independently to the side of the bed, walk around the bed to their walker and then begin walking down the hall without assistance.

Staff interview with a Personal Support Worker (PSW) revealed that resident #050 was independent with transfers and walked short distances on their own using a wheeled

walker. In terms of toileting, the resident may need set up assistance from one staff but was otherwise independent. The PSW indicated that when the resident first returned from hospital they required extensive assistance from staff to perform their activities of daily living. In addition, they had put a number of interventions in place, because the resident continued to try to get up without assistance. The staff member shared that this was not as much of a risk now as the resident was more independent in terms of their mobility. When asked if the interventions were still being used, the staff member indicated that a specified device was not necessary but they were unsure about the second device. When the staff member checked the resident's room they confirmed that the device was in place, but was not activated.

Staff interview with the lead for the falls program confirmed that Resident #050 had specified devices put in place after they returned from hospital. The staff member acknowledged that the resident had improved with respect to their independence with walking and transfers and that the devices may not be necessary during the day.

During an interview with the Registered Practical Nurse they acknowledged that Resident #050 no longer required total assistance of two persons for toileting as outlined in the plan of care. The staff member acknowledged that the resident's plan of care with respect to toileting and falls had not been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

7. Resident #003 was admitted to hospital with a specified diagnosis.

When resident #003 returned from the hospital record review revealed that a Personal Support Worker documented at 2100 hours that the resident had returned from hospital at 1500 hours. Resident #003 also returned with a prescription. There was no noted assessment of resident #003 done by registered staff until 29 hours after returning to the home.

Inspector #519 reviewed the contents of the emergency medication box and confirmed that this box contained the prescribed medication. Interview with a registered staff member and the Director of Care confirmed that resident's #003 primary physician would have been available to obtain readmission orders and that after that there would have been an on-call physician available.

Resident #003 was not reassessed and the plan of care was not reviewed and revised when their care needs changed. [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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan; and ensuring that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee ensured that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home's policy titled Weight Change, policy number N&FSCN-13 dated as reviewed September 2015, indicated that at admission, all residents were to have their height and weight measured and recorded within 72 hours of admission and that heights were to be completed on an annual basis.

During stage one of the inspection it was identified that:

Resident #043 was admitted to the home on a specified date in 2014 however, the resident's height was not completed until twelve days following admission. The resident's weight was documented as being completed six days following admission.

Resident #044 was admitted to the home on a specified date in 2014. The resident's height and weight were completed seven days following admission.

Resident #045 was admitted to the home on a specified date in 2015. The resident's weight and height were completed six days following admission.

Resident #046 was admitted to the home on a specified date in 2015. The first recorded weight was 12 days following admission and the first recorded height was 21 days following admission.

Residents #040, #041, #042, #001 and #004 had no annual heights recorded

A review of residents from the stage one census admitted over an identified eleven month period, identified nine residents. Eight of the nine residents failed to have heights and/or weights completed within 72 hours of admission.

Interview with the Resident Assessment Instrument (RAI) Coordinator confirmed that the height for resident #004 and others had not been completed annually.

Interview with the Director of Care (DOC) confirmed that the expectation was for resident weight and heights to be done within 72 hours of admission and for heights to be reassessed annually. The DOC confirmed that heights were not consistently completed for residents of the home.

The licensee failed to ensure that the Weight Change policy was complied with when annual heights were not completed for residents of the home and when heights and weights were not recorded within 72 hours of admission. [s. 8. (1) (b)]

2. The home's policy titled "Resident Self-Administration", Index number: 03-04-10, date of last review June 23, 2014, stated that in Long Term Care Facilities or Nursing Homes the nurse and/or consultant pharmacist would perform a self-medication audit to assess the resident's ability to self-medicate as per facility policy. The assessment should ensure that the resident understands:

a. the use of the drug
b. the need of the drug
c. the potential side effects of the drug
d. the need for monitoring and documentation of the use of the drug; and
e. the importance of keeping the drug safe and secure (if the resident is permitted to retain the drug in their possession).

This assessment would be repeated every twelve months or as per facility policy. The assessment results were to be documented in the resident's chart.

The policy also stated that if the medication was to be left at the bedside or in the resident's room, the physician order must specify this.

Resident # 061 had an order for a specified medication to be self-administered, may keep at bedside.

Resident # 062 had an order for a specified medication, may self-administer, but no order that it could be kept at the bedside.

Resident # 063 had an order for a specified treatment, may self administer, but no order that it could be kept at the bedside.

During an interview with the Director of Care (DOC) on November 2, 2015, at 1015 hours, a list was obtained of the residents who currently self administer medication in the home. She stated that the Nurse Practitioner had written the orders that these residents may self administer but had not done the self medication audit to assess the resident's ability to self medicate.

During observation of the Resident's medical record on November 2, 2015, at 1130 hours, it was noted that resident #062 and resident #063 did not have an order for medication to be kept at the bedside.

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with when the DOC confirmed that the self-medication audit to assess residents #061, #062, #063's ability to self-medicate as per facility policy was not done, and the orders to keep medication at the bedside for Resident #062 and #063 were not written. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee ensures that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #8: 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 resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

During stage one of this Resident Quality Inspection it was identified on October 21, 2015, at 1515 hours that the resident-staff communication and response system at the bedside in a specified room failed to activate when the red button was pushed. The resident was observed to be laying in bed at the time.

Personal Support Workers interviewed outside the specified room indicated that because the resident had a specified device, the call bell at the bedside would not activate and that residents on that home area don't activate the call bell.

The Director of Care was notified of the non-functioning call bell.

On October 22, 2015, at 1015 hours, the resident was observed in bed with the the call bell in hand. The call bell was again checked and failed to activate.

At 1045 hours the call bell was again checked with the Director of Care who indicated that the cancel button for the call bell sticks. The call bell activated at this time.

Interview with the Manager of Environmental Services on November 2, 2015, indicated that the home has no Preventive Maintenance for the resident-staff communication and response system and that maintenance depends on staff to report malfunctioning call bells.

The licensee failed to ensure that the resident-staff communication and response system in a specified room could be easily seen, accessed and used by the resident, staff and visitors at all times. [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 ensuring that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents;

(g) shall comply with any requirements respecting the matters provided for in clauses (a)

through(f) that were provided for in the regulations, and
(h) shall deal with any additional matters as may be provided for in the regulations.

Review of the home's policies ADMIN-005-1 and ADMN-005-3 titled Zero Tolerance of Abuse and Neglect with a revision/reviewed date of February 2013 revealed that it did not include the following:

- Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident, are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

- The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

- That an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it; that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy and what changes and improvements are required to prevent further occurrences; that the results of the analysis are considered in the evaluation; that the changes and improvements are promptly implemented; and that a written record of the evaluation including the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared.

The Director of Care confirmed that these items were not included in the home's policy to promote zero tolerance of abuse and neglect. [s. 20. (2)]

2. Regulation 96 indicated that the long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents identified measures and strategies to prevent abuse and neglect.

Review of the home's policies ADMIN-OO5-1 and ADMIN-005-3 titled Zero Tolerance of Abuse and Neglect both with reviewed dates of February 2013 revealed that the policy did not identify measures and strategies to prevent abuse and neglect. This was

confirmed by the Director of Care.

Interview with the Director of Care also identified that the home's Zero Tolerance of Abuse and Neglect policy had been revised and approved by the Board following revision in September 2015. The policy was initially provided to Inspectors by the Director of Care. Review of the September 2015 policy identified additional missing items required in the Act and the Regulations. The policy accessible by staff of the home, dated as reviewed February 2013, was the policy reviewed during this inspection. [s. 20. (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 ensuring that the written policy to promote zero tolerance of abuse and neglect of residents complies with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the Regulations and ensuring that the policy deals with any additional matters provided for in the regulations, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, within six weeks of the admission of the resident, and at least annually after that.

During an interview with the family member of resident #004 it was identified that there had been no invitation forwarded to the family to attend an annual care conference for this resident in the last year.

A review of the residents medical record determined that the most recent annual care conference held for resident #004 was on a specified date in 2013.

An interview with the Director of Care, who was responsible for ensuring that Care Conferences were completed confirmed that an annual conference had not occurred. [s. 27. (1)]

2. In Stage I of the Resident Quality Inspection (RQI), Inspector #192 spoke with the family of resident #011 and it was identified that they were not invited to participate in an annual care conference.

A review of resident #011's records, specifically the progress notes and 'Assessments' failed to demonstrate that an annual care conference took place in 2015.

On October 28, 2015, Inspector #629 interviewed the Director of Care who confirmed that an annual care conference for resident #011 should have taken place in 2015 and did not.

The Director of Care also indicated that if an annual care conference had taken place, for resident #011, documentation would have been made in either the progress notes or in an 'Assessment'.

The licensee failed to ensure that a care conference of the interdisciplinary team was held, at least annually. (629) [s. 27. (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 ensuring that a care conference of the interdisciplinary team is held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any within six weeks of the admission of the resident, and at least annually after that, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Resident #001 was identified in the plan of care and in signage posted in the resident's room, to require the assistance of two staff to provide total assistance for toileting and transfers. The resident required assistance with product change, clothing adjustment and personal hygiene.

On a specified date in 2015, one staff member was observed to enter resident #001's room, ask the resident if they required assistance with toileting, retrieve required personal protective equipment and reenter the room. The resident's door was closed during the provision of care. Continuous observation confirmed that no additional staff entered the resident room. The staff member was observed to exited the room after a fifteen minute period.

The Personal Support Worker providing care to resident #001 was interviewed by Inspector 629 and identified that they had provided hygiene and grooming care and had toileted the resident . The staff member confirmed that the resident required full assistance with two staff, using a hygiene sling for toileting.

The licensee failed to ensure that resident #001 was toileted with the assistance of two staff as specified in the plan of care and that staff used safe transferring and positioning techniques. [s. 36.]

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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

On a specified date resident #050 was readmitted to the home.

Review of clinical records did not reveal a completed skin assessment when the the resident returned from hospital.

During an interview with the Registered Nurse in charge of the skin and wound care program they stated that it was the home's expectation that when a resident returned from hospital they received a skin assessment to determine if there were any areas of altered skin integrity. If the resident is found to have an area of altered skin integrity then the resident would have weekly skin assessments until this had resolved. The staff member confirmed that there was no skin assessment completed for resident #050 when they returned from hospital. [s. 50. (2) (a) (ii)]

2. Record review revealed that resident #003's skin risk assessment (Braden scale) identified moderate risk. Resident #003 was admitted to hospital and returned to the home six days later. Record review revealed that on a specified date in 2015, resident #003 had a dressing on their buttocks. Two days later the dressing was removed and a skin assessment was done revealing that resident #003 had an area of altered skin integrity.

Resident #003 who was at risk for altered skin integrity did not receive a skin assessment by a member of the registered nursing staff upon return from hospital. This was confirmed by the registered staff and by the Director of Care. [s. 50. (2) (a) (ii)]

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 ensuring that a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the recreational and social activities program included, assistance and support to permit residents to participate in activities that may be of interest to them if they were not able to do so independently.

Resident #001 was observed on four specified dates in 2015, and was not observed to be involved in recreational activities.

Interview with the Clinical Lead Recreation Therapy identified that all documentation related to recreational programs refused or attended was included in Point of Care.

Review of the Point of Care records for resident #001 for August, September and October 2015, confirmed by the Clinical Lead Recreation Therapy identified that resident #001 had the potential to attend programs if provided assistance and support to do so.

During August 2015, resident #001 was documented to have received redirection on one occasion and attended one large group program. No refusals were identified.

During September 2015, resident #001 was documented to have received redirection on one occasion, attended one large group program and one outing. No refusals were identified.

During October 2015, resident #001 was documented to have received redirection on two occasions and attended one large group program. No refusals were identified.

The plan of care for resident #001 identified that they were at risk of wandering and progress notes included several elopements. The resident was identified as indicating they were lonely.

Interview with the Recreation Manager confirmed that resident #001 was not provided assistance and support to permit the resident to participate in activities that may be of interest to them. [s. 65. (2) (f)]

2. During a family interview, it was noted that the Substitute Decision Maker (SDM) for a specified resident felt that the resident was not being encouraged and assisted to attend activities .

A review of the residents plan of care indicated that their general activity preference was music, and that their awake time was mornings and afternoon.

The activity calendar for the month of October provided a minimum of 25 music programs that the resident could potentially have attended.

During interview with the recreation therapy staff responsible for resident #004's home area, the staff member was unable to provide a specific date when the resident had last attended a program. The staff member estimated that it had been approximately two months since the resident had been in attendance at an activity.

The licensee failed to ensure that resident #004 was provided the assistance and support to attend activities of interest to them. (614) [s. 65. (2) (f)]

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 ensuring that the recreational and social activities program included, assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

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

Resident #001 was observed on four specified dates in 2015 with a specified device in place. The outer right corner of the device was noted to be in disrepair. The current state of the device would prohibit the ability to clean and sanitize the device.

Interview with the Manager Rehabilitation and Outpatient Services identified that there was a process of referral when a device was in disrepair. The Manager Rehabilitation and Outpatient Services confirmed that no referral was sent in relation to the specified device. The Manager Rehabilitation and Outpatient Services confirmed he would expect that a referral would be sent from nursing staff when a device was in disrepair.

The licensee failed to ensure that the process for repair of the device used by resident #001 was implemented when their table top required repair. [s. 90. (2) (b)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

Observation during stage one of this Resident Quality Inspection identified sink drains in bath rooms in specified rooms that appeared brown in colour and the finish was coming off which would make effective cleaning of the sinks in these rooms difficult.

Interview with Manager of Environmental Services confirmed that it would be the expectation that housekeeping staff would report when fixtures were wearing or in poor repair so that they could be replaced.

The Manager of Environmental Services indicated that the home did not have a procedure developed and implemented to ensure that the plumbing fixtures were maintained and kept free of corrosion. [s. 90. (2) (d)]

3. The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents was 49 degrees Celsius or less.

Review of the Hot Water Report provided by the Manager of Environmental Services, indicated that on November 1, 2015, at 1900 hours on the 2 West home area the water temperature was recorded to be 122 degrees fahrenheit (F) which was equivalent to greater than 49 degrees Celsius.

Interview with the Manager of Environmental Services confirmed that the home does not have a procedure developed and implemented to ensure that the temperature of water serving all bathtubs, showers and hand basins used by residents was 49 degrees Celsius or less. [s. 90. (2) (g)]

4. The licensee has failed to ensure that procedures were developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents were maintained at a temperature of at least 40 degrees Celsius.

Interview with the Manager of Environmental Services confirmed that the home does not have a procedure developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Review of the Hot Water Report completed by security of the home indicated that hot water temperatures were below the equivalent of 40 degrees Celsius when recorded at the following times;

-October 24, 2015, at 2010 hours on the 1 East home area (103.6 F);
-October 25, 2015, at 1835 hours on the 2 East home area (100.3 F);
-October 27, 2015, at 2030 hours on the 2 North home area (100.5 F).

On October 29, 2015, Inspector 519 received a complaint from a family member indicating that there had been no hot water for bathing on a specified home area for a few days.

The licensee failed to ensure that procedures were developed and implemented to ensure that the hot water temperature serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius. [s. 90. (2) (i)]

5. The licensee has failed to ensure that procedures were developed and implemented to ensure that, if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents had access to hot water.

Interview with the Manager of Environmental Services indicated that the home did not have a procedure related to the monitoring of water temperatures once per shift in

random locations where residents have access to hot water.

Review of the Hot Water Report confirmed that temperatures in the home were recorded once daily, usually during the evening. [s. 90. (2) (k)]

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 ensuring that procedures are developed and implemented to ensure that; all equipment, devices, assistive aids and positioning aids in the home are kept in good repair; plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; temperature of the water serving all bathtubs, showers and hand basins used by residents is 49 degrees Celsius or less; hot water temperature serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; and if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home were labeled properly and kept inaccessible to residents at all times.

On October 26, 2015, at 1348 hours a housekeeping cart was observed on 2 East home area outside of room 612, positioned against the railing and unattended.

The bottom of the housekeeping cart contained multiple containers of cleaning product including toilet bowl cleaner that indicated goggles and chemical resistant gloves were required for use, and Virox 5 which indicated personal protective equipment was required when used. A full pail of soiled clothes was observed to have been left unattended on the cart and was fully accessible to residents passing by.

On October 26, 2015, at 1410 hours a housekeeping staff member was interviewed and confirmed that all chemicals should have been locked in the available locked cabinet.

The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times when a housekeeping cart was left unattended with hazardous chemical and soiled housekeeping cloths accessible to residents of the home. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all hazardous substances at the home are labeled properly and kept inaccessible to residents at all times, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's

instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following requirements were met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act; staff apply the physical device in accordance with any manufacturer's instructions.

During stage one of this Resident Quality Inspection, October 22 and 23, 2015, it was observed that 7/40 residents were using devices with a loose fit.

Review of medical records identified that it was the practice in the home to indicate on the plan of care that seat belts and other devices were to be applied according to manufacturers instructions. Staff interviewed were unable to describe what "applied according to manufacturers instructions" meant indicating that the Occupational Therapist would provide training when the device was applied. No manufacturers instructions were able to be provided.

Interview with the Registered Practical Nurse-Device Program Lead identified that when a seat belt was not fitting, there was a referral process to the Occupational Therapist who would reassess the seat belt. (192)

Resident #006 was observed to be sitting in their wheelchair with a specified device in place. Resident #006 was not able to undo the device. The device was loose and the inspector could fit more than four finger widths between the device and the resident.

The Registered Practical Nurse confirmed that the device was too loose and indicated that a referral had to be sent to Occupational Therapy to get the device adjusted.

The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions. [s. 110. (1) 1.]

2. The licensee has failed to ensure that the documentation included any instructions relating to the order.

Resident #006 had a specified device in place. The physician's order confirmed that resident #006 had the specified device in use. The Long Term Care-Device Information for Consent and Physician Order for resident #006 indicated that resident #006 had a device. There was no documentation that included instructions relating to the order.

Resident #030 had specified devices in place. The Long Term Care-Device Information

for Consent and Physician Order for resident #030 indicated that resident #030 had devices in use. There was no documentation that included any instructions relating to the order.

The Registered Practical Nurse-Device Program Lead confirmed that the documentation did not include any instructions relating to the order. [s. 110. (7) 3.]

3. The licensee has failed to ensure that documentation included the person who applied the device and the time of the application.

Review of resident #006's record revealed that staff were applying a specified device. The documentation did not include the person who applied the device and the time of the application.

Review of resident #030's record revealed that staff were applying a specified devices. The documentation did not include the person who applied the devices and the time of the application.

This was confirmed by the Registered Practical Nurse-Device Program Lead and by the Director of Care. [s. 110. (7) 5.]

4. Resident #001 was restrained by a specified device. The use of the device was included in the Point of Care documentation and instructed staff to apply the device, monitor the resident hourly and release and reposition the resident every two hours. Hourly time frames for checks and release/repositioning were provided between 0630 hours and 2130 hours daily.

Review of the October 2015, documentation in Point of Care identified that staff completed bulk charting, signing both hourly checks of the table tray and release/repositioning at the same time.

Interview with the Director of Care and the Registered Practical Nurse responsible for restraints in the home, confirmed that the documentation did not tell the reader when the restraint was applied, whether the resident was checked or if the restraint was released and the resident was repositioned.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including the person who applied the

device and the time of application. [s. 110. (7) 5.]

5. The licensee has failed to ensure that the documentation included all assessment, reassessment and monitoring, including the resident's response.

Record review and observation revealed that resident #006 had a specified device in use.
Record reviewed revealed that the documentation did not include all assessment, reassessment and monitoring, including the resident's response. Documentation included only that the resident had the device in place.

Record review and observation revealed that resident #030 had a specified devices in use. Record review revealed that the documentation did not include all assessment, reassessment and monitoring, including the resident's response. Documentation included that the resident had devices in place.

The Registered Practical Nurse-Device Program Lead and Director of Care confirmed that the documentation did not include all assessments, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

6. The licensee has failed to ensure that the documentation included every release of the device and repositioning.

Resident #006 was observed to have a a specified device in use. Record review revealed that the documentation indicated that resident #006 had a specified device and it was applied. The documentation did not include every release of the device and repositioning.

Resident #030 was observed to have specified devices in use. Record review revealed that the documentation indicated that resident #030 had the devices applied, the documentation did not include every release of the device and repositioning.

The Registered Practical Nurse-Device Lead and the Director of Care confirmed that the documentation did not include every release of the device and repositioning. [s. 110. (7) 7.]

7. Resident #001 was restrained by a specified device. The use of the device was included in the Point of Care documentation and instructed staff to apply the device,

monitor the resident hourly and release and reposition the resident every two hours. Hourly time frames for checks and release/repositioning were provided between 0630 hours and 2130 hours daily.

Review of the October 2015, documentation in Point of Care identified that staff completed bulk charting, signing both hourly checks of the table tray and release/repositioning at the same time.

Interview with the Director of Care and the Registered Practical Nurse responsible for restraints in the home, confirmed that the documentation did not tell the reader when the restraint was applied, whether the resident was checked or if the restraint was released and the resident was repositioned.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented, including every release of the device and all repositioning. [s. 110. (7) 7.]

8. The licensee has failed to ensure that the documentation included the removal of the device, including time of removal or discontinuance and the post-restraining care.

Record review and observation revealed that resident #006 had a specified device in use. Record review revealed that the documentation did not include the time the device was removed and the post-restraining care. The documentation just included that the resident had a device.

Record review and observation revealed that resident #030 had specified devices in use. Record review revealed that the documentation did not include the time the devices were removed and the post-restraining care. The documentation just included that the resident had devices and that they were applied.

The Registered Practical Nurse-Device Program Lead and the Director of Care confirmed that the documentation did not include the removal of the device, including time of removal or discontinuance and the post-restraining care. [s. 110. (7) 8.]

9. Resident #001 was restrained by a specified device. The use of the device was included in the Point of Care documentation and instructed staff to apply the device, monitor the resident hourly and release and reposition the resident every two hours. Hourly time frames for checks and release/repositioning were provided between 0630

hours and 2130 hours daily.

Review of the October 2015, documentation in Point of Care identified that staff completed bulk charting, signing both hourly checks of the table tray and release/repositioning at the same time.

Interview with the Director of Care and the Registered Practical Nurse responsible for restraints in the home, confirmed that the documentation did not tell the reader when the restraint was removed.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented, including the removal of the device. [s. 110. (7) 8.]

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 ensuring that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act; staff apply the physical device in accordance with any manufacturer's instructions.

Ensuring that the documentation related to restraining of a resident by a physical device includes; any instructions relating to the order, the person who applied the device and the time of the application, includes all assessment, reassessment and monitoring, including the resident's response; every release of the device and repositioning; and removal of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #17: 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, (a) drugs were stored in an area or a medication cart, (i) that was used exclusively for drugs and drug-related supplies, (ii) that was secure and locked, (iii) that protected the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and (iv) that complied with manufacturer's instructions for the storage of the drugs.

During the medication room observation on Floor Two East wing (Linden Court and Cherrywood Lane) and North wing (Willow's Way and Whitebirch Path), there were expired stock medications found in the storage cupboards.

The medication room on Linden Court and Cherrywood Lane was checked and the following expired medications were found: Glycerin Suppositories, expiry date of August 2015, and Refresh Tears Ophthalmic drops, expiry date of April 15, 2015. These medications were confirmed to be expired by the Registered Practical Nurse (RPN).

The medication room on Willow's Way and Whitebirch Path was checked and the following expired medications were found: Potassium Chloride Solution, expired September 2015, and Glycerin Suppositories, expiry date of September 2014. These medications were confirmed to be expired by the RPN.

The licensee has failed to ensure that drugs were stored in manner that complied with manufacturer's instructions for the storage of the drugs (e.g. expiration dates) when

expired medications were found in the storage cupboards on two separate medication rooms. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During the medication room observation it was noted that there was a vial of Ativan 4 miligram (mg)/mililitre (ml) stored in an unlocked refrigerator.

The Registered Practical Nurse(RPN) on duty confirmed it was in the unlocked refrigerator and it was not the correct place to store a controlled drug as it was to be double locked (in a locked container in the locked medication room).

During an interview with the Director of Care, it was confirmed that the vial of Ativan 4 mg/ml should not have been placed in an unlocked refrigerator.

The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart when a vial of Ativan 4 mg/ml was stored in an unlocked refrigerator within the medication room. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that manufacturer's instructions for the storage of the drugs is complied with and that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was assisted with getting dressed as required, and was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

On three specified occasions resident #004 was observed without socks and/or footwear.

A review of the residents plan of care indicated that when the staff assisted this resident to dress they were to ensure clothing and footwear were clean and appropriate.

It was confirmed with the full time Registered Nurse on the resident care area that resident #004 did not have appropriate clean footwear in place. [s. 40.]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

Interview with the Manager of Environmental Services confirmed that the home did not have a procedure developed and implemented for addressing incidents of lingering offensive odours.

Observation of resident #001 in a specified room on four specified dates in 2015, identified on each occasion an offensive odour was identified within the room. It was observed that the room was carpeted with stains and worn spots noted on the carpet.

The room was observed with the Manager of Environmental Services who confirmed an offensive odour in the room. The specific source of the odour could not be determined, however the Manager of Environmental Services suggested it may be related to the carpet.

The Manager of Environmental Services indicated that there was a schedule for the replacement of carpet in resident rooms, however was not aware when the carpet in the specified room was scheduled to be replaced.

The licensee failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Issued on this 18th day of January, 2016

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) :	DEBORA SAVILLE (192), CAROLYN MCLEOD (614), DOROTHY GINTHER (568), MEREDITH MCQUADE (629), SHARON PERRY (155), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2015_226192_0060
Log No. / Registre no:	027948-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 21, 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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_171155_0014, CO #002;

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 for resident's #001, #006, #030 and all other residents restrained by a physical device, the significant risk to the resident or that another person would suffer serious bodily harm if the resident were not retrained, is identified in the plan of care.

Grounds / Motifs :

1. Resident #001 was observed in 2015, with multiple devices in use.

The plan of care for resident #001 failed to include the use of all of the devices

observed, when reviewed.

Interview with a Registered Practical Nurse (RPN)- Device Program Lead confirmed that use of assistive devices were not included in resident #001's plan of care. The RPN confirmed that under tasks in Point Click Care staff were instructed what devices to apply and the frequency of checks required for each device. The RPN confirmed that a specified device could not be removed by the resident and was a restraint.

Review of the Resident Device Assessments identified use of a device related to a risk of falls but failed to identify that the resident or another person would be a significant risk if the resident were not restrained.

Interview with an RPN on the home area identified that assessment of risk to the resident or risk to others would be completed by the Occupational Therapist (OT) when applying the device. Interview with the Manager Rehabilitation and Outpatient Services identified that when the OT received a referral related to application of a Restraint/Personal Assistive Services Device (PASD) the OT was assessing for the appropriate device with
the understanding that the nursing department had already determined that a device was required due to risk to the resident or others.

The licensee 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.

This legislation has been issued twice previously as a compliance order during inspections initiated November 19, 2014 and April 16, 2015. Three of four residents reviewed in relation to the use of restraints were identified to have one or more restraining devices in place which increased the potential risk to the resident. Three of three residents with restraints had not had the significant risk to the resident or another person identified in the plan of care. (192)

2. Resident #030 was observed to have specified devices.

Review of the Resident Device Assessment for resident #030, indicated that resident #030 used the specified devices. The section on the assessment where it indicated the risk of injury to self and the risk of injury to others was blank.

The Long Term Care-Device Information for Consent and Physician Order, under nursing device assessment indicates N/A (staff confirmed N/A means not applicable) for significant risk of self harm and significant risk of harm to others.

Interview with staff revealed that resident #030 used the devices to prevent the resident from falling.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the plan of care for resident #030 did not identify significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. (155)

3. 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.

Resident #006 was noted to use a specified device.

Review of the Resident Device Assessment for resident #006, indicated that resident #006 used the specified device. The section on the assessment where it indicated the risk to injury to self and risk of injury to others was blank.

The Long Term Care-Device Information for Consent and Physician Order, under nursing device assessment indicated N/A (staff confirmed N/A means not applicable) for significant risk of self harm and significant risk of harm to others.

Interview with staff revealed that resident #006 had the device to prevent the resident from falling.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the plan of care for resident #006 did not identify significant risk that the resident or another person would suffer serious bodily harm if the resident was not restrained. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

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. 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 residents #001, #006, #030 and all other residents restrained by a physical device have alternatives to restraining that have been considered and tried, where appropriate, but would not be, or have not been effective to address the significant risk to the resident or another person if the resident were not restrained, identified within the resident's plan of care.

Grounds / Motifs :

1. Resident #001 was found to attempt to self ambulate and a referral to Occupational Therapy related to use of a specified device was initiated in 2013. An assessment was conducted and a specified device was applied to the

residents wheelchair, for reassessment in one month.

Record review identified that when the device was applied, the resident became verbally aggressive requesting that the device be removed and indicating the device was causing discomfort. An area of redness was identified which was identified to be from the device.

A progress note completed by the Occupation Therapist indicated a a specified device was in place and was difficult for staff to open. There was no further reference to the device in documentation reviewed.

On a specified date it was identified in a physician/nurse practitioners note that the resident had pain and swelling in relation to use of the specified device.

The device, which restrained the resident, remained in place throughout the resident's admission with no indication of alternatives to the device documented as having been trialed.

Review of assessments conducted using the Resident Device Assessment (v2) indicated that the device remained in use. The most recent assessment, indicated that alternatives to restraining used included responsive behaviour interventions, physiotherapy/occupational therapy involvement, medication review, involvement of recreation programming and pain assessment.

Interview with the Director of Care confirmed that the identified alternatives on the Resident Device Assessment (v2) were assessments and not alternative interventions. Interview with the Clinical Lead for Recreation Therapy confirmed that when Responsive Behaviour and Recreation Programming interventions are initiated the restraint remains in place and are therefore not alternatives to restraining.

The plan of care identified under application of a device that nursing alternatives had been trialed and were unsuccessful but did not identify what nursing alternatives had been trialed or why those alternatives were ineffective.

The licensee failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. (192)

2. Resident #030 was noted to use specified devices. Review of the Resident Device Assessment for resident #030, indicated that resident #030 used the specified devices. The section on the assessment where it indicated alternatives trialed, indicated tools used to assess the resident but did not include the alternatives considered, and tried, but that had not been effective in addressing the risk.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the restraint plan of care for resident #030 did not include alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk. (155)

3. The licensee has failed to ensure that the restraint plan of care included alternatives to restraining that were considered, and tried, but had not been effective in addressing the risk.

Resident #006 was noted to use a specified device. Review of the Resident Device Assessment for resident #006, indicated that resident #006 used the specified device. The section on the assessment where it indicated alternatives trialed indicated tools used to assess the resident but did not include the alternatives considered, and tried, that had not been effective in addressing the risk.

Interview with the Registered Practical Nurse-Device Program Lead confirmed that the restraint plan of care for resident #006 did not include alternatives to restraining that were considered, and tried, but have not been effective in addressing the risk. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

Order # / Ordre no : 003

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. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Order / Ordre :

The licensee shall ensure that the policy Least Restraint/Device Process numbered 002-1 and 002-3 are reviewed and revised to include the requirement provided for in regulation 109 (a-g), including the following;

- duties and responsibilities of staff including who has the authority to apply a physical device to restrain a resident or release a resident from a physical device

-restraining under the common law duty pursuant to subsection 36(1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others.

-types of physical devices permitted to be used.

- how consent to the use of physical devices as set out in section 31 of the Act and the use of Personal Assistive Service's Device's (PASD's) as set out in section 33 of the Act is to be obtained and documented.

-alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and

- how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulation.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy to minimize the restraining of residents complied with such requirements as may be provided for

in the regulations.

Regulation 109 states that the licensee shall ensure that the home's written policy under section 29 of the Act deals with:

(b)(ii) addressing the duties and responsibilities of the staff, including who had the authority to apply or release a physical device.

c) restraining under the common law duty pursuant to subsection 36(1) of the Act when immediate action was necessary to prevent serious bodily harm to the person or others.

d) the types of physical devices permitted to be used.

e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASD's as set out in section 33 of the Act was to be obtained and documented.

f) alternatives to the use of physical devices, including how those alternatives are planned, developed and implemented, using an interdisciplinary approach.

g) how the use of restraining in the home would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary was done in accordance with the Act and the Regulation.

The home's policy titled Least Restraint/Device Policy, policy number Clinical-002-1 dated as reviewed October 2015, and the process titled Least Restraint/Device Process, process number Clinical-002-3 dated as reviewed October 2015, failed to address; the duties and responsibilities of the staff, including who had the authority to apply or release a physical restraint, restraining under common law duty pursuant to subsection 36(1) of the Act when immediate action was necessary to prevent serious bodily harm to the person or others, the types of physical devices permitted to be used, how consent to the use of physical devices as set out in section 31 of the Act and the use of PASD's as set out in section 33 of the Act was to be obtained and documented, alternatives to the use of physical devices, including how those alternatives are planned, developed and implemented, using an interdisciplinary approach and how the use of restraining would be evaluated to ensure minimizing of restraining and to ensure that any restraining that was necessary

was done in accordance with the Act and Regulation

Interview with the Director of Care confirmed that the home's policy and procedure failed to include each of the above items.

The licensee failed to ensure that the home's written policy to minimize the restraining of residents complied with the requirements provided for in the Regulation.

The licensee has an outstanding order in relation to complying with the restraint policy. Since the last inspection (April 16, 2015) the home made changes to the policy and at the time of this inspection the policy fails to comply with the requirements of the regulations. There are two previous compliance orders related to the restraining of residents. The risk to residents and of ongoing non-compliance in relation to the restraining of residents is high if the home's policy fails to provide clear direction on all requirements for the use of restraints as identified within the legislation. The concern is widespread in that all residents using restraints are impacted. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 29, 2016

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. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee shall ensure that the person designated as the Long-Term Care Home's Administrator works regularly in that position, on site at the home for a least 35 hours per week.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Administrator worked regularly in that position on site at the home for the following amount of time per week:

In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week.

St. Joseph's Health Centre has 144 + 96 Long-Term Care beds, in addition there were Complex Continuing Care and Rehabilitation beds, a day surgery and outpatient clinics.

Interview with the designated Administrator clarified that their role was as Vice President of Clinical Services, Chief Nursing Executive.

The Vice President of Clinical Services, Chief Nursing Executive identified they were responsible for all clinical services within the St. Joseph's Health Centre

and all clinical managers report to them.

The Vice President of Clinical Services, Chief Nursing Executive confirmed that their responsibilities included Long-Term Care (LTC), Complex Continuing Care, Rehabilitation, Outpatient Clinics and Local Health Integration Network (LHIN) wide programs.

The Vice President of Clinical Services, Chief Nursing Executive confirmed their work week was 37.5 hours and that 70% of their time was spent on LTC.

The Vice President of Clinical Services, Chief Nursing Executive confirmed that staff of the home would go to the Director of Care (DOC) with concerns related to LTC.

The Vice President of Clinical Services, Chief Nursing Executive did indicate that the new President (May 2015) would have a role in LTC – indicating that the role of Administrator for Long-Term Care was a shared role.

During interview with the DOC it was identified that the Vice President of Clinical Services, Chief Nursing Executive had no hands-on responsibility for LTC. The DOC also confirmed that the workload of the Vice President of Clinical Services, Chief Nursing Executive had a broad scope and that the focus was not solely on LTC.

The licensee failed to ensure that the home's Administrator worked regularly in that position, on site at the home, for at least 35 hours per week.

There is no previous history with this area of non-compliance. The scope is wide spread as the Administrator is to be in charge of the home and to be responsible for its management. The severity is (2) minimal harm or potential for actual harm. The home has repeat compliance orders in relation to the use of physical restraints. (192)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 15, 2016

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. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,

(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals;

(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and

(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that members of the registered nursing staff permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical only if:

(a) The staff member has been trained by a member of the registered nursing staff in the administration of topicals

(b) The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and

(c) The staff member who administers the topical does so under the supervision of the member of the registered nursing staff

The plan shall be submitted electronically to Long Term Care Homes Inspector Debora Saville of the Performance Improvement and Compliance Branch of the Ministry of Health and Long-Term Care, London Service Area Office, 130 Dufferin Avenue, London, Ontario at debora.saville@ontario.ca by December 31, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that a member of the registered nursing staff could permit a staff member who was not otherwise permitted to administer a drug to a resident to administer a topical only if:

(a) The staff member had been trained by a member of the registered nursing staff in the administration of topicals

(b) The member of the registered nursing staff who was permitting the administration was satisfied that the staff member could safely administer the topical; and

(c) The staff member who administered the topical did so under the supervision of the member of the registered nursing staff

During an interview with the Director of Care, it was stated that Personal Support Workers (PSWs) had been applying topical creams to residents under their care.

She stated that the PSWs were expected to review the education on how to complete this task through the Medisystem Portal. She then confirmed that the home did not have a formal way of knowing if PSW's had completed this education as the Registered Staff do not supervise the PSWs applying the creams, or sign off on a form declaring they are competent to complete the task independently. The Registered Staff sign the treatment record that the creams had been applied.

The DOC stated that they would soon be implementing a Learning Management System in the home that would track the educational activity of all of the direct care staff but that was not in effect as of October 30, 2015.

There is no compliance history in relation to this legislation. The scope is widespread in that no Personal Support Workers have had training in relation to the application of topical treatments and the severity is a level 2, minimal harm or potential for actual harm as untrained staff are currently applying the topical treatments. (519)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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 21st day of December, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : DEBORA SAVILLE

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