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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 6, 2016	2016_264609_0007	001649-16	Resident Quality Inspection

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road SUDBURY ON P3E 0B6

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

ST. JOSEPH'S VILLA, SUDBURY
1250 South Bay Road SUDBURY ON P3E 6L9

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

CHAD CAMPS (609), SARAH CHARETTE (612), SYLVIE LAVICTOIRE (603)

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): February 22-26, February 29 and March 1-4, 2016.

This inspection included a Follow-up on two compliance orders issued during a previous inspection (#2015_320612_0020) related to non-compliance with the home's personal support services program and responsive behaviours. Seven Complaints related to improper care, infection control practices and inadequate staffing levels were also inspected upon as well as one Critical Incident the home submitted related to a resident who had fallen.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Services Manager (FSM), Unit Assistant, Manager of Environmental Services (MES), Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Executive Assistant (EA), Information Technology (IT) support staff, Food Services Aides (FSAs), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), residents and Substitute Decision Makers (SDMs).

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed numerous licensee policies, procedures and programs, complaint logs, internal investigations, purchase orders, relevant health care records, training logs and council meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **17 WN(s)**
- **9 VPC(s)**
- **8 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

During inspection (#2015_320612_0020) a compliance order was issued related to s. 8. (1) (b) whereby the home was to have ensured that there was an adequate number of PSWs to meet the needs of all the residents at all times, for all shifts and on all units.

Three complaints were submitted to the Director in October and November 2015 related to insufficient staffing of PSWs to meet the needs of the residents.

Inspector #609 reviewed the PSW staffing levels for the home during a particular time frame, which indicated the home was short a defined amounts of full PSW shifts on specified days.

A review of the home's Family Council minutes for November and December 2015 as well as February 2016 by Inspector #612 outlined that "staff shortages are an ongoing frustration for council members".

In an interview with Inspector #609, an identified resident said that on a particular day, they did not receive a specified intervention as indicated in their plan of care. The identified resident also stated that the specified intervention was missed often.

A review of the health care records for the identified resident indicated they were not provided the specified intervention as indicated in the resident's plan of care on particular days.

In an interview with Inspector #609, the Administrator said that the home did not have a process to ensure that when the specified intervention was missed that it was made up by staff.

In an interview with Inspector #609, personal support staff said that they were present and working a particular day and verified a unit of the home was short a defined number of full PSWs during a shift. As a result of the staff shortage, four identified residents did not receive specified interventions as indicated in their plans of care.

In an interview with Inspector #609, personal support staff said that they were present and working on a particular day and verified a unit of the home was short a defined number of PSWs. As a result of the shortage of staff a specified intervention was not

provided to all their assigned residents.

In an interview with Inspector #609, the DOC said that it was the expectation of the home that the organized program of personal support services for the home met the assessed needs of the residents. They also reported that the two particular days whereby the home was short of personal support staff and two specified interventions were not performed by personal support staff, the organized program of personal support services did not meet the assessed needs of the residents. [s. 8. (1) (b)]

2. On a particular day, Inspector #609 observed multiple residents waiting in an identified dining room for as long as one hour before the breakfast meal service began at 0900 hours.

On another particular day, Inspector #612 observed that the breakfast meal service for an identified dining room began at 0900 hours.

A review of the home's policy titled "Meal Service Routine" indicated that the breakfast meal service was to begin at 0830 hours.

In an interview with Inspector #609, the Administrator said that on two particular days, two identified units of the home were each short a defined number of PSWs during the shift which resulted in late breakfast meal services. The Administrator also stated that it was the expectation and policy of the home that the breakfast meal service was to begin at 0830 hours. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Observations of an identified resident during the inspection by Inspector #612 found a specified number and position of bed rails engaged on their bed.

In an interview with Inspector #612, the Manager of Environmental Services (MES) stated that the home did conduct an assessment of each resident's bed system and potential zones of entrapment but admitted the residents themselves were not assessed in order to minimize the risks of bed rail use. The MES verified that both the resident and the resident's bed system were to have been assessed.

In an interview with Inspector #609, the DOC said that there was no specific assessment conducted by the home to assess each resident with regards to their specific bed system. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Inspector #603 reviewed the health care records for an identified resident which indicated the resident had a procedure done on a particular day and subsequently required specified interventions. The health care records found no identified assessment using an instrument specifically designed for the assessment was completed for the identified resident.

In an interview with Inspector #603, registered staff said that they had noted the resident had specific interventions but did not know the reason for the interventions or if there was any follow up care. Registered staff also stated that they had not assessed the resident.

In an interview with Inspector #603, the ADOC indicated that the assessment was to be completed and been documented in the resident's health care records and that this did not occur for the identified resident. [s. 50. (2) (b) (i)]

2. On a particular day, Inspector #612 observed an identified resident with a specified intervention.

In an interview with Inspector #612, registered staff stated that they implemented the specified intervention.

A review of the health care records for the identified resident contained no documentation of the identified assessment or the specified intervention.

In an interview with Inspector #612, registered staff verified that no assessment was conducted on the identified resident.

In an interview with Inspector #612, the ADOC said that it was the expectation of the home that when a resident experienced a specified situation the assessment and an identified form were required by registered staff to complete and that this did not occur. [s. 50. (2) (b) (i)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

During inspection (#2015_320612_0020) a compliance order was served on January 8, 2016, related to O.Reg 79/10, s.54, whereby all staff of the home were to have completed education related to the home's responsive behaviour program. This education was to have been completed by February 5, 2016.

Inspector #609 reviewed the home's staff training logs as of March 2016 related to the home's Responsive Behaviour program found that 80 of 152 staff or 53 per cent of the home's staff did not complete the required education.

In an interview with Inspector #609, the ADOC said that it was the expectation of the home that all staff were to have completed the education on the Responsive Behaviour program and that 80 staff members had not completed the training in the allotted time. [s. 54.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily and weekly menus were

communicated to residents.

On a particular day, Inspector #603 observed that on an identified unit the posted weekly menu was different from the posted daily menu.

In an interview with Inspector #603, food services staff stated that the Food Services Aides (FSAs) were to change the menus over the weekend and acknowledged that the menus were not changed because over the weekend the home was short two FSAs.

In an interview with Inspector #603, the FSM indicated that it was the home's expectation that staff were to post updated daily and weekly menus on each unit and that this did not occur on the identified unit. [s. 73. (1) 1.]

2. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On a particular day Inspector #603 observed that three identified residents were all served their dessert while still eating their main course.

In an interview with Inspector #603, food services staff stated that they had no choice but to serve the dessert with the main course as they had other duties to attend to.

In an interview with Inspector #603, the ADOC and the FSM both indicated that the home's expectation was that all residents would have been served course by course unless otherwise indicated by the resident or the resident's assessed needs and that the three identified residents did not have this assessed need. [s. 73. (1) 8.]

3. On a particular day, Inspector #603 observed that during the dinner meal service on an identified unit where 29 out of the 30 residents were served an uncut meat entree. None of the residents were given a knife and the staff did not cut the meat. Residents were observed having difficulty cutting and eating the meat. A total of 12 residents were observed who did not receive any knife to cut their food nor assistance from staff to cut their food.

In an interview with Inspector #603, registered staff stated that none of the residents on the identified unit get a knife. For this reason, after being served their meals, the residents who required assistance to cut their food would have to wait for staff to assist.

In an interview with Inspector #603, the FSM stated that the staff did have access to knives to offer to any resident as needed and that it was the expectation of the home that residents would have been offered a knife or timely assistance to cut their food. [s. 73. (1) 9.]

4. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On a particular day, Inspector #612 observed an identified resident during the lunch meal service sitting with their head on the table not eating their meal.

In an interview with Inspector #612, registered staff stated that the staff cued the identified resident to eat and normally staff were available to assist the resident but there were no staff available at this time.

On another particular day, the identified resident was observed sitting with their head on the table. Staff rubbed the resident's back to wake them up and placed their juice in front of them on the table. The resident leaned forward with their hair in the soup. Staff returned, rubbed the resident's back so they would sit up. They then placed the soup in front of the resident who proceeded to lean forward again with their hair in the soup. No staff provided assistance to the resident while they ate.

A review of the health care records for the identified resident indicated that the resident required specified interventions from staff for eating.

In an interview with Inspector #612, registered staff and the Registered Dietitian (RD) both said that the resident required specified interventions for eating and that the resident did not receive the specified interventions they required during the cited observations.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that all residents were to have been fed in a manner consistent with their needs and that the identified resident was not fed in a manner consistent with their needs. [s. 73. (1) 9.]

5. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

a) On a particular day, Inspector #603 observed the dinner meal service on an identified

unit and noted that three identified residents were positioned in a specified manner, while eating.

In an interview with Inspector #603, personal support staff said they did not know why they were positioned in the specified manner.

A review of the plans of care for the three identified residents found no mention of the specified manner of positioning observed while eating their meals.

A review of the identified unit’s diet list did not indicate that the three identified residents required the specified manner of positioning during meals.

b) On a particular day, Inspector #603 observed the dinner meal service on an identified unit where a registered staff member stood while feeding an identified resident.

In interviews with Inspector #603, registered and personal support staff both stated that staff were to only feed residents while sitting at eye level with the resident.

In interviews with Inspector #603, the ADOC and the FSM both stated that it was the home's expectation that when staff assisted with the feeding of a resident, they were to sit at eye level with the resident and that the identified registered staff member did not sit at eye level to assist with the feeding of the identified resident on a particular day. [s. 73. (1) 10.]

6. The licensee has failed to ensure that staff members assisted only one or two residents at the same time that needed total assistance with eating or drinking.

On a particular day, Inspector #603 observed during the dinner meal service on an identified unit a member of the personal support staff feeding three residents at a single table.

In interviews with Inspector #603, registered and personal support staff both stated that the staff were to feed only two residents at a time.

In interviews with Inspector #603, the ADOC and the FSM both stated that it was the home's expectation that if the staff were to assist with feeding of a resident, the staff were to only assist up to two residents at the same time and that more than two residents were assisted with feeding at the same. [s. 73. (2) (a)]

Additional Required Actions:

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

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

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 there was a written plan of care for each resident that set out the planned care for the resident.

A complaint was submitted to the Director in March 2015 which alleged an identified resident was improperly cared for related to a defined concern.

Inspector #612 reviewed the health care records for the identified resident outlined that a single assessment was completed on a particular day to assess the defined concern and no others. The health care record further indicated that prior to the identified resident's discharged from the home, the completed quarterly Minimum Data Set (MDS) identified that the resident had experienced the defined concern.

A review of the plan of care for the identified resident found no focus, goals or interventions in the resident's plan of care which specifically addressed the resident's defined concern.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that any resident experiencing the defined concern would have had care set out in the resident's plan of care and that no focus specific to defined concern was set out in the plan of care for the identified resident. [s. 6. (1) (a)]

2. On a particular day, Inspector #612 interviewed an identified resident who stated that they had specific interventions required by staff who were not providing them.

In an interview with Inspector #612, personal support staff said that staff were aware of the specific interventions and ensured that the interventions were provided.

A review of the plan of care for the identified resident found no mention of specified interventions.

In an interview with Inspector #612, registered staff they said that it was the expectation of the home that the written plan of care set out the planned care for the resident and that this did not occur related to the specified interventions for the identified resident. [s. 6. (1) (a)]

3. The licensee has failed to ensure that that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident.

In an interview with Inspector #603, an identified resident said that at times they had an identified medical concern and that they received a specific intervention which was often effective.

A review of the health care records for the identified resident outlined a physician's order for intervention and that it was being utilized by the resident.

In interviews with Inspector #603, registered and personal support staff both said that the identified resident had an identified medical concern and that the specific intervention was usually effective.

A review of the plan of care for the identified resident found no mention or directions to staff related to identified medical concern.

In an interview with Inspector #603, the ADOC said that it was the expectation of the home that if a resident required specific interventions it should have been identified in the plan of care for the resident and that there was no clear direction to staff in the plan of care related the identified medical concern for the identified resident. [s. 6. (1) (c)]

4. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On a particular day, an identified resident said to Inspector #609 that they had requested multiple times for a specific intervention related to an identified medical concern. The identified resident also stated the home told them that "if I do it for one, I have to do it for them all" and declined their requests.

In an interview with Inspector #609, the FSM said that they did say the quoted statement above to the identified resident. The FSM further stated that identified resident could accept when and what the home had or find their own way. [s. 6. (2)]

5. 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.

In an interview with Inspector #603, the Substitute Decision Maker (SDM) for an identified resident said that the resident had identified medical concerns and required specific interventions.

A review of the plan of care for the identified resident indicated that staff were to provide a specific intervention at a defined frequency.

In an interview with Inspector #603, personal support staff said that on a particular day the specific interventions were not provided to the identified resident. [s. 6. (7)]

6. On a particular day, Inspector #603 observed staff serve an identified resident a combination of foods.

A review of the diet list indicated that the identified resident was to have received a specific intervention.

In an interview with Inspector #603, food services staff said that the identified resident did not receive the specific intervention as it was not required. [s. 6. (7)]

7. Observations of an identified resident by Inspector #612 during three meal services on particular days noted; the staff did not encourage the resident to eat, and the resident's intake was poor throughout the meal services; a defined intervention was provided to the resident at the beginning of their meal; the resident was provided with peach juice and a regular texture vegetable at dinner.

A review of the plan of care for the identified resident indicated; the resident required constant encouragement and guidance during meals; drink a specific juice (not peach juice); provide textured vegetables and a defined intervention after food had been offered.

In an interview with Inspector #612, registered staff said that it was the expectation that the plan of care for the identified resident was to guide the care that was provided to the resident and acknowledged that the care specified was not always followed by staff.

In an interview with Inspector #612, the FSM said that the care set out in the plan of care was to have been provided to the resident as specified in the plan.

In an interview with Inspector #612, the ADOC said that the nutritional care set out in the plan of care, was not provided to the identified resident as specified in the plan. [s. 6. (7)]

8. Observations of an identified resident by Inspector #603 showed the resident asleep in bed with a specified intervention applied incorrectly.

A review of the plan of care for the identified resident indicated staff were to have ensured that the resident's specified intervention was applied correctly.

In an interview with Inspector #603, personal support staff they stated that the identified resident was to have the specified intervention applied correctly and that this did not occur when the identified resident was returned to bed. [s. 6. (7)]

9. On a particular day, Inspector #612 observed an identified resident without a specified intervention applied to the resident while they slept.

A review of the plan of care for the identified resident indicated staff were to have applied a specified intervention when the resident was in bed.

In interviews with Inspector #612, registered and personal support staff all stated that the identified resident should have had the specified intervention applied.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that care was provided as specified in the plan of care and that this did not occur for the identified resident. [s. 6. (7)]

10. In an interview with Inspector #603, the Substitute Decision Maker (SDM) for an identified resident said that the resident was to wear a specified intervention at all times. The SDM stated that at times the specified intervention was not available.

A review of the plan of care for the identified resident indicated that the resident was to wear the specified intervention at all times.

A review of the health care records for the identified resident indicated that the resident's specified intervention was not available for a particular time frame.

Observations of the identified resident on a particular day, showed no applied specified intervention.

In an interview with Inspector #603, registered staff said that the identified resident was to wear the specified intervention as specified in the plan of care and that the resident was not wearing them and that they were not in the resident's room. Registered staff stated there was a defined number of days in the cited time frame whereby the identified

resident did not have the specified intervention applied. [s. 6. (7)]

11. Inspector #603 reviewed of the plan of care for an identified resident which indicated that staff were to have provided specified interventions in the resident's room.

Observations of the identified resident's room showed no use of the specified interventions.

In an interview with Inspector #603, registered staff stated that in the case of not providing the specified interventions to the identified resident, the home did not provide care as specified. [s. 6. (7)]

12. On a particular day, Inspector #612 observed during the lunch meal service, an identified resident sitting with their head on the table not eating.

Observations of the identified resident on another particular day, during the lunch meal service showed the resident sitting with their head on the table, though staff alerted the resident to the meal placed in front of them, the resident did not eat and no staff provided assistance to the resident. Observations on another day of the identified resident during the lunch meal service showed an intervention was provided to the identified resident who did not eat any of their main meal.

A review of the diet list for the identified resident indicated specific interventions which staff did not provide to the resident and interventions that were provided to the resident were not identified on the diet list.

A review of the plan of care for the identified resident indicated that a specific intervention was to be provided at nourishment passes not during meals. The plan of care also indicated that the resident required specific interventions by staff that were not provided during the observations of the resident.

In an interview with Inspector #612, registered staff stated that the specific interventions were not provided by staff on a particular day as there were no staff available.

In an interview with Inspector #612, personal support staff stated that because the identified resident did not eat any of their main meal on a particular day they were not provided with a specified intervention.

In an interview with Inspector #612, the RD and FSM both said that staff were to have followed the diet list and the nourishment list while in the dining room because it provided direction in regards to the identified resident's care needs. The RD acknowledged that the staff were not providing care as specified in the plan of care of the resident as indicated in the plan of care. [s. 6. (7)]

13. On a particular day, Inspector #612 observed an identified resident in a specific position in bed.

A review of the plan of care for the identified resident indicated that when the resident was positioned in bed, defined instructions were to be followed by staff.

In an interview with Inspector #612, personal support staff verified the direction provided in the resident's plan of care was correct and that the resident was not positioned as per the instructions.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that care set out in the plan was to have been provided to the identified resident and that this did not occur. [s. 6. (7)]

14. During the course of the inspection an identified resident indicated to Inspector #609 that they were consistently not provided with a specified intervention.

A review of the plan of care for the identified resident indicated a specific intervention was to be provided to the resident .

An review of a particular time frame of the specified intervention logs for the identified resident showed that 27 per cent of the time the specified intervention was not provided to the resident.

In an interview with Inspector #609, personal support staff said that the identified resident had a specific intervention that when the unit was short would not have been performed or performed minimally.

In an interview with Inspector #609, the ADOC said that it was the expectation of the home that care set out in the plan of care was provided to the residents and that 27 per cent of the time the specified intervention for the identified resident was not provided. [s. 6. (7)]

15. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Three complaints were submitted to the Director related to improper care of residents.

a) Inspector #609 reviewed a specified intervention log for an identified resident, which indicated that on a particular day, "not applicable" was the response documented for the resident's specified intervention despite having not received the intervention because of a shortage of personal support staff that afternoon.

In an interview with Inspector #609, personal support staff said that when the unit was short of staff and they were unable to provide a specified intervention they documented the care as 'not applicable".

b) A review of a specified intervention log for an identified resident showed that on a particular day, assistance was provided to the resident to perform an intervention.

In an interview with Inspector #609, personal support staff said that they documented that the specified intervention was completed for the identified resident on the particular day, despite having not provided any assistance related to a shortage of personal support staff.

In an interview with Inspector #609, the DOC and ADOC both said that it was the expectation of the home that care set out in the plan of care was documented and that there was inconsistent and inaccurate documentation of the provision of care set out in the plan of care for the two identified residents. [s. 6. (9) 1.]

16. The licensee has failed to ensure that the resident's 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.

Inspector #612 reviewed the plan of care for an identified resident, which indicated that the resident had specific and defined interventions for continence.

A review of the most recent quarterly assessment for the identified resident indicated that the resident had a different set of defined interventions.

In interviews with Inspector #612, registered and personal support staff both said that the identified resident had a change in condition and now required a different set of interventions than what was identified in the resident's plan of care and should have been revised. [s. 6. (10) (b)]

17. A complaint was submitted to the Director in March 2015 that alleged the home used poor infection prevention and control practices during an infectious outbreak.

Inspector #609 reviewed the Outbreak line listings for five residents identified an Outbreak during a particular time frame and verified three or 60 per cent of those residents did not have subsequent interventions outlined in their plans of care in effect at that time.

A review of the home's policy titled "Initiating Isolation" last revised April 17, 2014, made no reference to the revision of the plan of care for a resident placed on isolation.

In an interview with Inspector #609, the DOC said that it was the expectation of the home that when a resident's care needs changed, such as being identified during an Outbreak, that their plan of care was to have been updated and that this did not occur. [s. 6. (10) (b)]

18. Inspector #603 reviewed the last quarterly assessment for an identified resident which indicated the resident had a specific change in condition.

In an interview with Inspector #603, personal support staff verified the identified resident's specific change in condition.

A review of the health care records for the identified resident found that during a particular time frame, the resident did have the specific change in condition.

A review of the plan of care for the identified resident found no identification whatsoever of the resident's specific change in condition.

In an interview with Inspector #603, the ADOC said that it was the expectation of the home that the plan of care would have been revised at any time when the resident's care needs change and that there was no revision in the plan of care for the identified resident's specific change in condition. [s. 6. (10) (b)]

19. Inspector #603 reviewed of the plan of care for an identified resident, which indicated that staff were to provide specific interventions to assist the resident in defined time frames.

Observations of the identified resident on a particular day showed the resident without the specific interventions.

In an interview with Inspector #603, personal support staff said that the identified resident had an a change in condition and no longer required the specific interventions and that when a resident's care needs changed as in the case of the identified resident the plan of care should have been revised. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 006, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Inspector #603 interviewed the SDM for an identified resident who stated that in a meeting with the ADOC, had brought forward allegations of neglect and improper care of the resident and had not received any response from the home.

A review of the home's "Complaints, Concerns and Suggestions Process" policy indicated that the home would have responded promptly and professionally towards

resident or family complaints and concerns. The complaint shall have been investigated and resolved where possible, and a response provided to the complainant within 10 business days, and where the complaint alleged harm or risk of harm to one or more residents, the investigation will be commenced immediately.

In an interview with Inspector #603, the ADOC verified the meeting occurred with the SDM for the identified resident, that they were aware of the care complaints brought forward in the meeting and that they did not investigate the complaints. [s. 101. (1) 1.]

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

Inspector #612 reviewed the progress notes for an identified resident which indicated that the resident had brought forward complaints to a member of the home's staff who then brought forward the complaints to the ADOC on a particular day.

A review of the home's policy titled "Complaints, Concerns and Suggestions Process" indicated staff were required to have responded promptly and professionally towards resident or family complaints or concerns and that the Executive Assistant to the Administrator would have maintained a log of all verbal complaints not resolved within twenty-four hours and all written complaints received regardless of the amount of time recorded to resolve.

The policy further stated the log would consist of a documented record for each complaint received which included the nature of the written complaint or verbal complaint not resolved within 24 hours; the date the complaint was received; the action taken to resolve the complaint including date and time frames, the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any subsequent response made in turn by the complainant.

In an interview with Inspector #612, a member of the home's staff said that they had verbally notified the ADOC of the identified resident's care complaints on a particular day and again to the DOC on another particular day.

In an interview with Inspector #612, the ADOC denied being notified of the complaint and also stated that to their knowledge there was no consistent procedure used by the home for handling complaints.

In an interview with Inspector #612, the DOC stated that the care complaints specified by the identified resident was considered a complaint and once brought forward to the home they would have conducted an investigation which included following up with the complainant and interviewing staff. The DOC also stated that in the case of the care concerns brought forward by a member of the home's staff related to the care of the identified resident, the home was not in compliance with the Regulation or their own policy.

In an interview with Inspector #612 on March 3, 2016, the Administrator said that they had a complaint log where written complaints were tracked, but acknowledged that the DOC and ADOC managed verbal complaints independently and did not bring forward all the complaints that they had dealt with to have been accurately recorded. The Administrator verified that they were not following the home's policy related to documentation of complaints and maintaining the complaint log. [s. 101. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.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:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee fully respected and promoted the resident's right to have his or her lifestyle and choices respected.

Inspector #603 interviewed the Substitute Decision Maker (SDM) for an identified resident who said they had requested the home to provide the resident with a specific intervention during dinner meal service to ensure that the resident ate something. This request was denied by the home with no reason given.

A review of the plan of care for the identified resident indicated that the staff were to respect the resident's food needs.

In an interview with Inspector #603, the FSM acknowledged that the specific intervention requested by the SDM could have been ordered and served to the resident.

In an interview with Inspector #603, the Administrator said that they denied the request as they had other unrelated interventions to offer. [s. 3. (1) 19.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee fully respects and promotes the resident's right to have his or her lifestyle and choices respected, especially resident choices related to nutrition and hydration, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day.

Inspector #603 reviewed of the last quarterly assessment for an identified resident, which indicated the resident exhibited specific behaviours.

In an interview with Inspector #603, personal support staff said that identified resident did exhibit specific behaviours.

A review of the plan of care for the identified resident found no mention of the specific behaviours.

In an interview with Inspector #603, the DOC said that if a resident had been identified as having responsive behaviours, that these behaviours should have been identified at a minimum, in the plan of care. The DOC also stated that there was no identification of the specific behaviours in the plan of care for the identified resident. [s. 26. (3) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the responsive behaviour plan of care is based on an interdisciplinary assessment of the resident that includes any mood and behaviour patterns, including wandering, any identified responsive behaviours, and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the interdisciplinary falls prevention and management program was implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

Inspector #612 reviewed the health care records for an identified resident, which indicated the resident had fallen multiple times in a particular time frame. The health care records had no documentation to indicate that an inter-professional team review had been completed to review the resident's previous falls.

A review of the home's policy titled "Falls Prevention and Management" program indicated that an inter-professional team review was to be arranged if a resident had had three or more falls in three months.

In interviews with Inspector #612, registered and personal support staff all said that the resident was at risk for falls.

In an interview with Inspector #612, registered staff stated that when a resident had had three or more falls in three months an inter-professional team review was to be arranged however they were unsure who was responsible to arrange the review.

In an interview with Inspector #612, the DOC said that an interdisciplinary team review should have been completed for a resident that experienced three or more falls within a three month period and that this did not occur for the identified resident. [s. 48. (1) 1.]

2. A Critical Incident Report was submitted to the Director that indicated an identified resident had fallen on a particular day and was injured.

Inspector #612 reviewed the health care records for the identified resident which indicated the resident had fallen multiple times in a particular time frame. The health care records had no documentation to indicate an inter-professional team review had been completed to review the resident's previous falls.

In an interview with Inspector #612, the DOC said that an inter-professional team review should have been completed for a resident that experienced three or more falls within a three month period and that this did not occur for the identified resident. [s. 48. (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 to ensure that the interdisciplinary falls prevention and management program team meets promptly to assess residents who have fallen three or more times in three months, with the aim to reduce the incidence of falls and the risk of injury, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers were identified for the resident demonstrating responsive behaviours where possible.

In an interview with Inspector #603, the SDM for an identified resident said that the resident's increased responsive behaviours were at times triggered by a defined medical concern.

In an interview with Inspector #603, registered staff verified that the identified resident demonstrated increased responsive behaviours triggered by the defined medical concern.

A review of the plan of care for the identified resident found no triggers for responsive behaviours such as those triggered by the defined medical concern, were identified in the resident's plan of care. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, for each resident demonstrating responsive behaviours in the home that the behavioural triggers for the resident are identified, where possible, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (5) The licensee shall ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle. O. Reg. 79/10, s. 71 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that an individualized menu was developed for each resident whose needs could not have been met through the home's menu cycle.

On a particular day a family member of an identified resident told Inspector #609 that they had been purchasing and supplying a specified nutritional intervention for months as ordered by the physician and was told there was no way to order it by the home.

A review of the physician orders indicated the specified nutritional intervention.

In an interview with Inspector #609, the FSM said that they were aware of the order by the physician to provide the specified nutritional intervention and that the family was supplying it to the home.

In interview with Inspector #609, the ADOC and DOC both said that the home gave no indication that they were going to provide the physician ordered specified nutritional intervention if not bought by the family. [s. 71. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that an individualized menu is developed for each resident whose needs cannot be met through the home's menu cycle, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies were implemented related to the home's medication management system.

During the home's mandatory medication administration inspection Inspector #603 observed a member of the registered staff administer a defined amount of medication via an insulin pen to an identified resident. The registered staff member performed this task by picking up a pen in the resident's medication box, dialing the defined amount of medication picked up a needle, walked to the identified resident and administered the medication.

A review of the home's current policy "How to Administer Insulin (Insulin Pen)" indicated that the staff had to prime the needle before administering the medication, to ensure the right dose was given.

During the home's mandatory medication administration inspection the registered staff member did not prime the needle before administering the medication to the identified resident and should have. [s. 114. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written policies related to the home's medication management system are implemented, especially those related to the administration of injectable medications, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On a particular day, Inspector #603 observed a registered staff member picking up a medication cup with pre-poured medication in it from the drawer of an identified resident. The medication was to have been administered to the identified resident one hour previously.

In an interview with Inspector #603, the member of the registered staff said that they had pre-poured the medication earlier that morning as they knew the resident was going to need this medication. The registered staff member explained that they did not normally pre-pour medications because it did not comply with the Regulation. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked.

On a particular day, Inspector #603 observed an unattended and unlocked medication cart in the hallway.

In an interview with Inspector #603, registered staff said that they should have locked the medication cart before leaving it unattended.

Observations 30 minutes later showed the same medication cart left unattended and unlocked in the hallway.

During another interview with Inspector #603, registered staff said that they should have locked the medication cart before leaving it unattended. [s. 129. (1) (a)]

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

On a particular day, Inspector #603 observed a single-locked stationary cupboard for controlled substances in the medication room, on an specified unit. The cupboard had two locks on it but one was broken and could not lock.

In an interview with Inspector #603, registered staff said that the controlled substances cupboard was not double-locked as the second lock had been "broken for a while".

In an interview with Inspector #603, the DOC said that controlled substances cupboards needed to have been double-locked in the medication room and that they were not aware that one of the locks was broken. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provided direct care to residents received annual retraining in all the areas required under subsection 76 (7) of the Act.

a) Inspector #612 reviewed of the home's "Falls Prevention and Management" program which did not indicate any orientation or annual retraining requirements for staff.

A review of the annual training logs for 2015 indicated only 60.7 per cent of staff were trained or retrained on the home's Falls Prevention and Management program.

In an interview with Inspector #612, the DOC said that 39.1 per cent of staff were not trained or retrained in the home`s Falls Prevention and Management program.

b) Inspector #603 reviewed the home's "Skin and Wound Care" program which indicated that skin and wound care education would have been provided to new nursing staff during orientation and annually thereafter.

In an interview with Inspector #603, the DOC said that it was the expectation of the home that all staff involved in the care of skin and wounds were to have completed the required annual retraining in 2015 and that 20.4 per cent of the staff completed the training or retraining in the home's Skin and Wound Care program in 2015. [s. 221. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff who provide direct care to residents receives annual retraining in all the areas required under subsection 76 (7) of the Act, especially related to the falls and skin and wound programs, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home had his or her personal items, including personal aids such as dentures, glasses and hearing aids were labelled within 48 hours of admission and of acquiring, in the case of new items.

On two particular days, Inspector #609 observed 40 resident bathrooms, which found seven or 18 per cent had unlabelled personal items which included but not limited to unlabelled urinals, kidney basins, lotions, combs and toothbrushes and on one particular day each of the home's four tub rooms found 100 per cent had unlabelled and used personal items that included deodorants, razors and combs.

In an interview with Inspector #609, the ADOC said that it was the expectation of the home that all personal items were to have been labelled within 48 hours and that this did not occur. [s. 37. (1) (a)]

Issued on this 8th day of July, 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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHAD CAMPS (609), SARAH CHARETTE (612), SYLVIE LAVICTOIRE (603)
Inspection No. / No de l'inspection :	2016_264609_0007
Log No. / Registre no:	001649-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 6, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST. JOSEPH'S VILLA, SUDBURY 1250 South Bay Road, SUDBURY, ON, P3E-6L9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gloria Richer

To ST. JOSEPH'S HEALTH CENTRE OF SUDBURY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_320612_0020, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must prepare, submit and implement a plan for achieving compliance with the LTCHA, 2007 S.O. 2007, c. 8, s. 8 (1)(b) to ensure the organized program of personal support services in the home meets the assessed needs of the residents.

The plan must include:

a) How the home will develop and implement creative, consistent and ongoing strategies to recruit and retain direct care staff to ensure the required staffing levels are maintained within the home.

b) A written process with an implementation date to ensure that when the home is not fully staffed, that breakfast, lunch and dinner meal services start as specified in the home's policy.

c) A written process with an implementation date to ensure that missed specified interventions are tracked. The process will maintain a record of the missed interventions of residents and how the home will ensure, regardless of staffing levels, that missed interventions are made up promptly.

d) A monitoring system with an implementation date to ensure that a different specified intervention is provided at a minimum of twice a day to residents and/or in the manner specified in the resident's plan of care regardless of the home's staffing levels.

Please submit the plan, in writing, to Chad Camps, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Long-Term Care Inspections Branch, Long-Term Care Homes Division, 159 Cedar Street, Suite 403, Sudbury, Ontario, P3E 6A5.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

On a particular day, Inspector #609 observed multiple residents waiting in an identified dining room for as long as one hour before the breakfast meal service began at 0900 hours.

On another particular day, Inspector #612 observed that the breakfast meal service for an identified dining room began at 0900 hours.

A review of the home's policy titled "Meal Service Routine" indicated that the breakfast meal service was to begin at 0830 hours.

In an interview with Inspector #609, the Administrator said that on two particular days, two identified units of the home were each short a defined number of PSWs during the shift which resulted in late breakfast meal services. The Administrator also stated that it was the expectation and policy of the home that the breakfast meal service was to begin at 0830 hours. (609)

2. During inspection (#2015_320612_0020) a compliance order was issued related to s. 8. (1) (b) whereby the home was to have ensured that there was an adequate number of PSWs to meet the needs of all the residents at all times, for all shifts and on all units.

Three complaints were submitted to the Director in October and November 2015 related to insufficient staffing of PSWs to meet the needs of the residents.

Inspector #609 reviewed the PSW staffing levels for the home during a particular time frame, which indicated the home was short a defined amounts of full PSW shifts on specified days.

A review of the home's Family Council minutes for November and December 2015 as well as February 2016 by Inspector #612 outlined that "staff shortages are an ongoing frustration for council members".

In an interview with Inspector #609, an identified resident said that on a particular day, they did not receive a specified intervention as indicated in their plan of care. The identified resident also stated that the specified intervention was missed often.

A review of the health care records for the identified resident indicated they were not provided the specified intervention as indicated in the resident's plan of care on particular days.

In an interview with Inspector #609, the Administrator said that the home did not have a process to ensure that when the specified intervention was missed that it

was made up by staff.

In an interview with Inspector #609, personal support staff said that they were present and working a particular day and verified a unit of the home was short a defined number of full PSWs during a shift. As a result of the staff shortage, four identified residents did not receive specified interventions as indicated in their plans of care.

In an interview with Inspector #609, personal support staff said that they were present and working on a particular day and verified a unit of the home was short a defined number of PSWs. As a result of the shortage of staff a specified intervention was not provided to all their assigned residents.

In an interview with Inspector #609, the DOC said that it was the expectation of the home that the organized program of personal support services for the home met the assessed needs of the residents. They also reported that the two particular days whereby the home was short of personal support staff and two specified interventions were not performed by personal support staff, the organized program of personal support services did not meet the assessed needs of the residents.

The scope of this issue was a pattern of the home's organized program of personal support services not meeting the assessed needs of residents. During a previous inspection (#2015_320612_0020) a compliance order (CO) was served to the home on January 8, 2016, related to the home's personal support program not meeting the needs of residents. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of residents in the home. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Develop and implement an assessment tool to ensure that every resident that uses bed rails is assessed and their bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

b) Maintain a record of every resident specific assessment completed for the safe use of bed rails and if any assessment failed when and what the home did to address the safety risk.

c) Provide retraining to all staff who provide direct care to residents on the home's policies and procedures related to bed rails and their responsibilities to ensure bed rail safety.

d) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

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

Observations of an identified resident during the inspection by Inspector #612 found a specified number and position of bed rails engaged on their bed.

In an interview with Inspector #612, the Manager of Environmental Services (MES) stated that the home did conduct an assessment of each resident's bed system and potential zones of entrapment but admitted the residents themselves were not assessed in order to minimize the risks of bed rail use. The MES verified that both the resident and the resident's bed system were to have been assessed.

In an interview with Inspector #609, the DOC said that there was no specific assessment conducted by the home to assess each resident with regards to their specific bed system.

The scope of this issue was widespread lack of resident assessments to address resident risk related to bed rail use. There was more than one previous unrelated non-compliance in the last 36 months. The severity was determined to have been potential risk of actual harm to the health, safety and well-being to the residents in the home using bed rails. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall:

a) Identify every resident of the home who has altered skin integrity to ensure that it is identified and that interventions are developed and implemented to address the altered skin integrity.

b) Provide retraining to all nursing and personal support staff on the home's policies and procedures related to the Skin and Wound Care program, focusing on the roles and responsibilities of staff related to identification, assessment, treatment and evaluation of the skin and wound care needs of all residents in the home.

c) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

Inspector #603 reviewed the health care records for an identified resident which indicated the resident had a procedure done on a particular day and subsequently required specified interventions. The health care records found no identified assessment using an instrument specifically designed for the assessment was completed for the identified resident.

In an interview with Inspector #603, registered staff said that they had noted the resident had specific interventions but did not know the reason for the interventions or if there was any follow up care. Registered staff also stated that they had not assessed the resident.

In an interview with Inspector #603, the ADOC indicated that the assessment was to be completed and been documented in the resident's health care records and that this did not occur for the identified resident. (609)

2. On a particular day, Inspector #612 observed an identified resident with a specified intervention.

In an interview with Inspector #612, registered staff stated that they implemented the specified intervention.

A review of the health care records for the identified resident contained no documentation of the identified assessment or the specified intervention.

In an interview with Inspector #612, registered staff verified that no assessment was conducted on the identified resident.

In an interview with Inspector #612, the ADOC said that it was the expectation of the home that when a resident experienced a specified situation the assessment and an identified form were required by registered staff to complete and that this did not occur.

The scope of this issue was a pattern of lack of completed skin assessments for residents with altered skin integrity. During a previous inspection (#2014_282543_0017) a written notification (WN) was issued to the home on June 20, 2014, related to skin assessments not being completed on residents. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of the residents of the home exhibiting altered skin integrity. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2015_320612_0020, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall:

a) Provide retraining to all staff involved in the care of residents on all the home's policies and procedures related to the responsive behaviours program, focusing on minimizing of harmful altercations between and among residents.

b) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and (b) identifying and implementing interventions.

During inspection (#2015_320612_0020) a compliance order was served on January 8, 2016, related to O.Reg 79/10, s.54, whereby all staff of the home were to have completed education related to the home's responsive behaviour program. This education was to have been completed by February 5, 2016.

Inspector #609 reviewed the home's staff training logs as of March 2016 related to the home's Responsive Behaviour program found that 80 of 152 staff or 53 per cent of the home's staff did not complete the required education.

In an interview with Inspector #609, the ADOC said that it was the expectation of the home that all staff were to have completed the education on the Responsive Behaviour program and that 80 staff members had not completed the training in the allotted time.

The scope of this issue was a pattern of lack of completed retraining of staff in risk of altercations between residents. There was a previous ongoing CO related to this provision from inspection (#2015_320612_0020) on January 8, 2016. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of residents in the home cared for by staff not completely trained in responsive behaviours. (609)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall:

a) Ensure that the daily and weekly menus are communicated to residents and that this information is properly communicated to residents regardless of staffing levels within the home.

b) Perform an assessment of every resident of the home that utilizes a specified assistance device to ensure that the plan of care gives clear direction to staff regarding the positioning of the residents during and after meals.

c) Ensure that meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs and that the resident's plan of care gives clear direction to staff as to how to serve each resident.

d) Ensure that all eating aids, assistive devices, and staff assistance are provided to every resident to safely eat and drink as comfortably and independently as possible, focusing on how staff are to provide encouragement to feed with residents.

e) Provide retraining to all staff involved in the direct care of residents on the home's policies and procedures related to proper techniques for assisting residents with feeding, that staff do not feed more than two residents at a time, as well as the roles and responsibilities of each staff member to ensure compliance with the cited policies and procedures.

f) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that the daily and weekly menus were communicated to residents.

On a particular day, Inspector #603 observed that on an identified unit the posted weekly menu was different from the posted daily menu.

In an interview with Inspector #603, food services staff stated that the Food Services Aides (FSAs) were to change the menus over the weekend and acknowledged that the menus were not changed because over the weekend the home was short two FSAs.

In an interview with Inspector #603, the FSM indicated that it was the home's expectation that staff were to post updated daily and weekly menus on each unit and that this did not occur on the identified unit. (603)

2. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

On a particular day Inspector #603 observed that three identified residents were all served their dessert while still eating their main course.

In an interview with Inspector #603, food services staff stated that they had no choice but to serve the dessert with the main course as they had other duties to attend to.

In an interview with Inspector #603, the ADOC and the FSM both indicated that the home's expectation was that all residents would have been served course by course unless otherwise indicated by the resident or the resident's assessed needs and that the three identified residents did not have this assessed need. (603)

3. The licensee has failed to ensure that residents were provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

On a particular day, Inspector #612 observed an identified resident during the lunch meal service sitting with their head on the table not eating their meal.

In an interview with Inspector #612, registered staff stated that the staff cued the identified resident to eat and normally staff were available to assist the resident but there were no staff available at this time.

On another particular day, the identified resident was observed sitting with their head on the table. Staff rubbed the resident's back to wake them up and placed their juice in front of them on the table. The resident leaned forward with their hair in the soup. Staff returned, rubbed the resident's back so they would sit up. They then placed the soup in front of the resident who proceeded to lean forward again with their hair in the soup. No staff provided assistance to the resident while they ate.

A review of the health care records for the identified resident indicated that the resident required specified interventions from staff for eating.

In an interview with Inspector #612, registered staff and the Registered Dietitian (RD) both said that the resident required specified interventions for eating and that the resident did not receive the specified interventions they required during the cited observations.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that all residents were to have been fed in a manner consistent with their needs and that the identified resident was not fed in a manner consistent with their needs. (609)

4. On a particular day, Inspector #603 observed that during the dinner meal service on an identified unit where 29 out of the 30 residents were served an uncut meat entree. None of the residents were given a knife and the staff did not cut the meat. Residents were observed having difficulty cutting and eating the meat. A total of 12 residents were observed who did not receive any knife to cut their food nor assistance from staff to cut their food.

In an interview with Inspector #603, registered staff stated that none of the residents on the identified unit get a knife. For this reason, after being served their meals, the residents who required assistance to cut their food would have to wait for staff to assist.

In an interview with Inspector #603, the FSM stated that the staff did have access to knives to offer to any resident as needed and that it was the expectation of the home that residents would have been offered a knife or timely assistance to cut their food. (603)

5. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

a) On a particular day, Inspector #603 observed the dinner meal service on an identified unit and noted that three identified residents were positioned in a specified manner, while eating.

In an interview with Inspector #603, personal support staff said they did not know why they were positioned in the specified manner.

A review of the plans of care for the three identified residents found no mention of the specified manner of positioning observed while eating their meals.

A review of the identified unit's diet list did not indicate that the three identified residents required the specified manner of positioning during meals.

b) On a particular day, Inspector #603 observed the dinner meal service on an identified unit where a registered staff member stood while feeding an identified resident.

In interviews with Inspector #603, registered and personal support staff both stated that staff were to only feed residents while sitting at eye level with the resident.

In interviews with Inspector #603, the ADOC and the FSM both stated that it was the home's expectation that when staff assisted with the feeding of a resident, they were to sit at eye level with the resident and that the identified registered staff member did not sit at eye level to assist with the feeding of the identified resident on a particular day. (603)

6. The licensee has failed to ensure that staff members assisted only one or two residents at the same time who needed total assistance with eating or drinking.

On a particular day, Inspector #603 observed during the dinner meal service on an identified unit a member of the personal support staff feeding three residents at a single table.

In interviews with Inspector #603, registered and personal support staff both stated that the staff were to feed only two residents at a time.

In interviews with Inspector #603, the ADOC and the FSM both stated that it was the home's expectation that if the staff were to assist with feeding of a resident, the staff were to only assist up to two residents at the same time and that more than two residents were assisted with feeding at the same.

The scope of this issue was widespread non compliance related to lack of

required care provided to residents to eat and drink safely, comfortably and independently. During previous inspections (#2015_282543_0003, #2014_282543_0017 and #2014_210169_0005) a Written Notification (WN) was issued to the home May 8, 2015, a Voluntary Plan of Correction (VPC) was issued on June 20, 2014, and a CO was served on March 17, 2014 all related to O.Reg 79/10, s. 73. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of residents in the home not provided the care they need for feeding. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

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 : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that every resident is reassessed and their plan of care is reviewed and revised whenever the resident's care needs change or care set out in the plan is no longer necessary, including but not limited to the plans of care for three specific residents.

b) Develop and implement a monitoring system to ensure that when residents' needs change (especially resident changes identified by direct care staff, when a resident returns from hospital, is placed on isolation or in each of their quarterly MDS assessments) that they are reassessed, their plans of care revised, that staff are aware of the changes and provide care to the resident as specified in the plan.

c) Maintain documentation of how the required monitoring system was developed, when it was implemented and what the results have been.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's 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.

Inspector #603 reviewed of the plan of care for an identified resident, which indicated that staff were to provide specific interventions to assist the resident in defined time frames.

Observations of the identified resident on a particular day showed the resident without the specific interventions.

In an interview with Inspector #603, personal support staff said that the identified resident had an a change in condition and no longer required the specific interventions and that when a resident's care needs changed as in the case of the identified resident the plan of care should have been revised. (609)

2. Inspector #603 reviewed the last quarterly assessment for an identified resident which indicated the resident had a specific change in condition.

In an interview with Inspector #603, personal support staff verified the identified resident's specific change in condition.

A review of the health care records for the identified resident found that during a particular time frame, the resident did have the specific change in condition.

A review of the plan of care for the identified resident found no identification whatsoever of the resident's specific change in condition.

In an interview with Inspector #603, the ADOC said that it was the expectation of the home that the plan of care would have been revised at any time when the resident's care needs change and that there was no revision in the plan of care for the identified resident's specific change in condition. (609)

3. A complaint was submitted to the Director in March 2015 that alleged the home used poor infection prevention and control practices during an infectious outbreak.

Inspector #609 reviewed the Outbreak listings for five residents identified an Outbreak during a particular time frame and verified three or 60 per cent of those residents did not have subsequent interventions outlined in their plans of care in effect at that time.

A review of the home's policy titled "Initiating Isolation" last revised April 17, 2014, made no reference to the revision of the plan of care for a resident placed on isolation.

In an interview with Inspector #609, the DOC said that it was the expectation of the home that when a resident's care needs changed, such as being identified during an Outbreak, that their plan of care was to have been updated and that this did not occur. (609)

4. Inspector #612 reviewed the plan of care for an identified resident, which indicated that the resident had specific and defined interventions for continence.

A review of the most recent quarterly assessment for the identified resident indicated that the resident had a different set of defined interventions.

In interviews with Inspector #612, registered and personal support staff both said that the identified resident had a change in condition and now required a different set of interventions than what was identified in the resident's plan of care and should have been revised.

The scope of this issue was widespread lack of revision of the plans of care for residents when their care needs changed. There was more than one previous unrelated non compliance within the last 36 months. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of residents in the home provided care from plans of care not reviewed and revised when needs changed. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Provide retraining to all staff involved in the care of residents or the operation of the home in the policies and procedures of the home related to complaints, especially on the roles and responsibilities of each staff member in reporting, tracking and dealing with all written and verbal complaints received by staff in the home.

b) Provide retraining to the home's management team focusing on their roles and responsibilities in responding to, tracking and resolving complaints.

c) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. The licensee has failed to ensure that a documented record was kept in the home which included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to have been taken and any follow-up action required; (d) the final resolution, if any; (e) every

date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

Inspector #612 reviewed the progress notes for an identified resident which indicated that the resident had brought forward complaints to a member of the home's staff who then brought forward the complaints to the ADOC on a particular day.

A review of the home's policy titled "Complaints, Concerns and Suggestions Process" indicated staff were required to have responded promptly and professionally towards resident or family complaints or concerns and that the Executive Assistant to the Administrator would have maintained a log of all verbal complaints not resolved within twenty-four hours and all written complaints received regardless of the amount of time recorded to resolve.

The policy further stated the log would consist of a documented record for each complaint received which included the nature of the written complaint or verbal complaint not resolved within 24 hours; the date the complaint was received; the action taken to resolve the complaint including date and time frames, the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any subsequent response made in turn by the complainant.

In an interview with Inspector #612, a member of the home's staff said that they had verbally notified the ADOC of the identified resident's care complaints on a particular day and again to the DOC on another particular day.

In an interview with Inspector #612, the ADOC denied being notified of the complaint and also stated that to their knowledge there was no consistent procedure used by the home for handling complaints.

In an interview with Inspector #612, the DOC stated that the care complaints specified by the identified resident was considered a complaint and once brought forward to the home they would have conducted an investigation which included following up with the complainant and interviewing staff. The DOC also stated that in the case of the care concerns brought forward by a member of the home's staff related to the care of the identified resident, the home was not in compliance with the Regulation or their own policy.

In an interview with Inspector #612 on March 3, 2016, the Administrator said that they had a complaint log where written complaints were tracked, but acknowledged that the DOC and ADOC managed verbal complaints independently and did not bring forward all the complaints that they had dealt with to have been accurately recorded. The Administrator verified that they were not following the home's policy related to documentation of complaints and maintaining the complaint log.

The scope of this issue was widespread lack of responding and documenting complaints. There was more than one previous unrelated non compliance within the last 36 months. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of residents in the home when complaints were not responded to appropriately. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2016

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall:

a) Ensure that for every resident in the home, staff provide care as specified in each resident's plan of care.

b) Perform an assessment of all residents of the home to identify which residents require special treatments including but not limited to three specific interventions, to ensure that the plans of care for the identified residents include all interventions to manage their special treatments and that it is up to date.

c) Perform an assessment of all residents to identify which residents of the home are experiencing pain, to ensure that the plans of care for the identified residents include all interventions to manage their pain and that it is up to date.

d) Perform an assessment of all residents to identify which residents of the home have responsive behaviours, to ensure that the plans of care for the identified residents include all interventions to manage their behaviours and that it is up to date.

e) Perform an assessment of every resident of the home to identify which residents require incontinence care, to ensure that the plans of care for the identified residents include all interventions to manage their incontinence and that it is up to date.

f) Perform an assessment of every resident of the home to identify which residents require oral hygiene assistance, to ensure that the plans of care for the identified residents include all interventions to manage their oral hygiene needs

and that it is up to date.

g) Ensure that the oral hygiene required by an identified resident is provided to the resident as specified in the resident's plan of care, regardless of the staffing levels in the home.

h) Perform an assessment of every resident of the home to identify which residents require specific instructions to be followed by staff related to resident positioning in chairs and beds, to ensure that the plans of care for the identified residents include all interventions related to positioning and that it is up to date.

i) Ensure that the specified type of bath identified in the plan of care for an identified resident that are required to maintain the resident's health are provided regardless of the staffing levels of the home.

j) Provide retraining to all staff involved in the care of residents in the home's policies and procedures related to resident plans of care and staff's responsibilities to provide care as specified in each resident's plan of care. The retraining must also include focused education to direct care staff involved in the care of any of the residents identified in the required assessments that resulted in changes to the plans of care.

k) Maintain a record of the required retraining, who completed the retraining, when and what the retraining entailed.

Grounds / Motifs :

1. 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.

During the course of the inspection an identified resident indicated to Inspector #609 that they were consistently not provided with a specified intervention.

A review of the plan of care for the identified resident indicated a specific intervention was to be provided to the resident .

An review of a particular time frame of the specified intervention logs for the identified resident showed that 27 per cent of the time the specified intervention was not provided to the resident.

In an interview with Inspector #609, personal support staff said that the identified resident had a specific intervention that when the unit was short would not have been performed or performed minimally.

In an interview with Inspector #609, the ADOC said that it was the expectation of the home that care set out in the plan of care was provided to the residents and that 27 per cent of the time the specified intervention for the identified resident were not provided. (609)

2. On a particular day, Inspector #612 observed an identified resident in a specific position in bed.

A review of the plan of care for the identified resident indicated that when the resident was positioned in bed, defined instructions were to be followed by staff.

In an interview with Inspector #612, personal support staff verified the direction provided in the resident's plan of care was correct and that the resident was not positioned as per the instructions.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that care set out in the plan was to have been provided to the identified resident and that this did not occur. (612)

3. Observations of an identified resident by Inspector #612 during three meal services on particular days noted; the staff did not encourage the resident to eat, and the resident's intake was poor throughout the meal services; a defined intervention was provided to the resident at the beginning of their meal; the resident was provided with peach juice and a regular texture vegetable at dinner.

A review of the plan of care for the identified resident indicated; the resident required constant encouragement and guidance during meals; drink a specific juice (not peach juice); provide textured vegetables and a defined intervention after food had been offered.

In an interview with Inspector #612, registered staff said that it was the expectation that the plan of care for the identified resident was to guide the care that was provided to the resident and acknowledged that the care specified was not always followed by staff.

In an interview with Inspector #612, the FSM said that the care set out in the plan of care was to have been provided to the resident as specified in the plan.

In an interview with Inspector #612, the ADOC said that the nutritional care set out in the plan of care, was not provided to the identified resident as specified in the plan. (612)

4. Inspector #603 reviewed of the plan of care for an identified resident which indicated that staff were to have provided specified interventions in the resident's room.

Observations of the identified resident's room showed no use of the specified interventions.

In an interview with Inspector #603, registered staff stated that in the case of not providing the specified interventions to the identified resident, the home did not provide care as specified. (603)

5. In an interview with Inspector #603, the Substitute Decision Maker (SDM) for an identified resident said that the resident was to wear a specified intervention at all times. The SDM stated that at times the specified intervention was not available.

A review of the plan of care for the identified resident indicated that the resident was to wear the specified intervention at all times.

A review of the health care records for the identified resident indicated that the resident's specified intervention was not available for a particular time frame.

Observations of the identified resident on a particular day, showed no applied specified intervention.

In an interview with Inspector #603, registered staff said that the identified resident was to wear the specified intervention as specified in the plan of care and that the resident was not wearing them and that they were not in the resident's room. Registered staff stated there was a defined number of days in the cited time frame whereby the identified resident did not have the specified intervention applied (603)

6. On a particular day, Inspector #612 observed an identified resident without a specified intervention applied to the resident while they slept.

A review of the plan of care for the identified resident indicated staff were to have applied a specified intervention when the resident was in bed.

In interviews with Inspector #612, registered and personal support staff all stated that the identified resident should have had the specified intervention applied.

In an interview with Inspector #612, the DOC said that it was the expectation of the home that care was provided as specified in the plan of care and that this did not occur for the identified resident. (612)

7. Observations of an identified resident by Inspector #603 showed the resident asleep in bed with a specified intervention applied incorrectly.

A review of the plan of care for the identified resident indicated staff were to have ensured that the resident's specified intervention was applied correctly.

In an interview with Inspector #603, personal support staff they stated that the identified resident was to have the specified intervention applied correctly and that this did not occur when the identified resident was returned to bed. (603)

8. On a particular day, Inspector #612 observed during the lunch meal service, an identified resident sitting with their head on the table not eating.

Observations of the identified resident on another particular day, during the lunch meal service showed the resident sitting with their head on the table, though staff alerted the resident to the meal placed in front of them, the resident did not eat and no staff provided assistance to the resident. Observations on another day of the identified resident during the lunch meal service showed an intervention was provided to the identified resident who did not eat any of their main meal.

A review of the diet list for the identified resident indicated specific interventions which staff did not provide to the resident and interventions that were provided to the resident were not identified on the diet list.

A review of the plan of care for the identified resident indicated that a specific intervention was to be provided at nourishment passes not during meals. The plan of care also indicated that the resident required specific interventions by staff that were not provided during the observations of the resident.

In an interview with Inspector #612, registered staff stated that the specific interventions were not provided by staff on a particular day as there were no staff available.

In an interview with Inspector #612, personal support staff stated that because the identified resident did not eat any of their main meal on a particular day they were not provided with a specified intervention.

In an interview with Inspector #612, the RD and FSM both said that staff were to have followed the diet list and the nourishment list while in the dining room because it provided direction in regards to the identified resident's care needs. The RD acknowledged that the staff were not providing care as specified in the plan of care of the resident as indicated in the plan of care. (612)

9. On a particular day, Inspector #603 observed staff serve an identified resident a combination of foods.

A review of the diet list indicated that the identified resident was to have received a specific intervention.

In an interview with Inspector #603, food services staff said that the identified resident did not receive the specific intervention as it was not required. (603)

10. In an interview with Inspector #603, the Substitute Decision Maker (SDM) for an identified resident said that the resident had identified medical concerns and required specific interventions.

A review of the plan of care for the identified resident indicated that staff were to provide a specific intervention at a defined frequency.

In an interview with Inspector #603, personal support staff said that on a particular day the specific interventions were not provided to the identified resident.

The scope of this issue was a pattern of care not provided to residents as specified in their plans. During previous inspections (#2015_320612_0020 and #2013_138151_0032) a VPC was issued to the home on January 8, 2015, and a CO was served on November 21, 2013. Both were related to care not provided to residents as specified in their plans. The severity was determined to have been potential risk of actual harm to the health, safety and well-being of residents not provided care as specified in their plans. (603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 6th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chad Camps

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