Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

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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
Feb 12, 2015	2015_226192_0013	000533-15, 002147-15	Critical Incident System

Licensee/Titulaire de permis

STEEVES & ROZEMA ENTERPRISES LIMITED
265 NORTH FRONT STREET SUITE 200 SARNIA ON N7T 7X1

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

ST ANDREW'S TERRACE LONG TERM CARE COMMUNITY
255 St. Andrew's Street CAMBRIDGE ON N1S 1P1

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

DEBORA SAVILLE (192)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 11, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator and Manager of Resident Care.

The Inspector reviewed medical records, work routines and incident investigation notes.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The plan of care for resident #001 indicated that the resident does make request for their preferred method of elimination at times, particularly through the night hours. Team members are responsible for ensuring that the resident is checked at ten minute intervals after making these requests.

In 2015 resident #001 rang their call bell and was found by staff to be using a specified medical device. Documentation indicated that the resident reported to staff that it felt like they had been using the device for hours.

The home's investigation into the incident identified that the resident started using the device, one hour and 35 minutes prior to ringing for assistance.

Interview with the Manager of Resident Care confirmed that staff had not complied with the plan of care when they did not check resident #001 every ten minutes after they started using the medical device. [s. 6. (7)]

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

The plan of care for resident #002 indicated under dressing that the resident refused to have specified clothing removed. The resident may agree to having adjustment for comfort, but not taking the item off except at specified times. Two staff are to be in attendance for dressing and undressing. If resident #002 is refusing or resistive and it is safe, then team members are to leave the resident and re-approach at a later time.

In 2015 resident #002 was assisted with undressing by two Personal Support Workers. The Personal Support Workers attempted to remove all of the residents clothing. The resident responded with physical and verbal aggression. Interview conducted by the home identified that staff were aware of the resident's preferences but attempted to remove all clothing. When the resident became physically resistive one of the staff members present confirmed they paused briefly (40 seconds) but then proceeded with care resulting in further physical and verbal aggression from the resident.

Resident #002 sustained injury as a result of the staff to resident interaction.

The licensee failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) In 2015 two Personal Support Workers provided care to resident #002. During the provision of care, resident #002 became resistive physically and verbally. Documentation review and interview confirmed that staff providing care continued to provide care, in spite of the resident's resistance to care and the resident sustained injury as a result of the actions of the staff providing care.

The licensee failed to protect resident #002 from abuse by anyone.

B) In 2015 resident #001 was found to have been left by staff of the home for a period of one hour and thirty-five minutes while using a medical device. The plan of care indicated the resident was to be monitored every ten minutes when using the device. Interview conducted by the home identified that staff failed to communicate to the oncoming shift that the resident was using the device and staff coming on shift failed to check the resident until the resident used their call bell to request assistance, one hour and twenty five minutes after the shift began.

The licensee failed to protect resident #001 from neglect by staff in the home.

Inspection 2015_226192_0003, log number 000090-15 resulted in this home having an outstanding compliance order related to section 19(1) (#001) with a compliance date of February 27, 2015. [s. 19. (1)]

Issued on this 17th day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBORA SAVILLE (192)
Inspection No. / No de l'inspection :	2015_226192_0013
Log No. / Registre no:	000533-15, 002147-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 12, 2015
Licensee / Titulaire de permis :	STEEVES & ROZEMA ENTERPRISES LIMITED 265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1
LTC Home / Foyer de SLD :	ST ANDREW'S TERRACE LONG TERM CARE COMMUNITY 255 St. Andrew's Street, CAMBRIDGE, ON, N1S-1P1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARK VAN DYKE

To STEEVES & ROZEMA ENTERPRISES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 ensure that care set out in the plan of care;
i) for resident #001 related to toileting is provided to the resident as specified in the plan and
ii) for resident #002 related to dressing is provided to the resident as specified in the plan.

Grounds / Motifs :

1. Previously issued as a VPC October 27, 2014.

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

The plan of care for resident #002 indicated under dressing that the resident refused to have specified clothing removed. The resident may agree to having adjustment for comfort, but not taking the item off except at specified times. Two staff are to be in attendance for dressing and undressing. If resident #002 is refusing or resistive and it is safe, then team members are to leave the resident and re-approach at a later time.

In 2015 resident #002 was assisted with undressing by two Personal Support Workers. The Personal Support Workers attempted to remove all of the residents clothing. The resident responded with physical and verbal aggression. Interview conducted by the home identified that staff were aware of the resident's preferences but attempted to remove all clothing. When the resident became physically resistive one of the staff members present confirmed they paused briefly (40 seconds) but then proceeded with care resulting in further physical and verbal aggression from the resident.

Resident #002 sustained injury as a result of the staff to resident interaction.

The licensee failed to ensure that care set out in the plan of care was provided to resident #002 as specified in the plan. (192)

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

The plan of care for resident #001 indicated that the resident does make request for their preferred method of elimination at times, particularly through the night hours. Team members are responsible for ensuring that the resident is checked at ten minute intervals after making these requests.

In 2015 resident #001 rang their call bell and was found by staff to be using a specified medical device. Documentation indicated that the resident reported to staff that it felt like they had been using the device for hours.

The home's investigation into the incident identified that the resident started using the device, one hour and 35 minutes prior to ringing for assistance.

Interview with the Manager of Resident Care confirmed that staff had not complied with the plan of care when they did not check resident #001 every ten minutes after they started using the medical device. (192)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 12th day of February, 2015

Signature of Inspector /
Signature de l'inspecteur :

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

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