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

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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
Jul 21, 2015	2015_380593_0015	S-000832-15	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.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

GILLIAN CHAMBERLIN (593), LINDSAY DYRDA (575), SARAH CHARETTE (612), TIFFANY BOUCHER (543)

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): May 25 - 29, June 1 - 5, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Nutrition Manager, Registered Nursing Staff, Registered Dietitian, Dietary Staff, Activation Staff, Maintenance Staff, Personal Support Workers (PSW), residents and family members.

The inspectors observed the provision of care and services to residents, observed staff to resident Interactions, observed resident to resident Interactions, observed residents' environment, reviewed resident health care records, reviewed staff training records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
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
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

12 WN(s)
6 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. (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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

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

Findings/Faits saillants :

1. During an inspection completed December 30, 2014 under inspection 2014_282543_0029, a compliance order was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.6. (1) (c) the licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #022 specifically related to transferring and/or mobility.

Inspector #543 reviewed resident #022's most recent Care Conference notes, which identified that this resident's mobility has decreased since admission, and now requires a specific device for transfers.

Inspector #543 reviewed this resident's most recent care plan which identified mobility goals and assistance required to achieve this. In terms of transferring, this resident's care plan identified that interventions would be addressed in the mobility section of the care plan. The mobility section of this resident's care plan did not identify this.

Inspector reviewed this resident`s most recent RAP triggers related to ADL Functional Rehabilitation Potential which identified that the resident requires assistance for locomotion on and off unit.

In an interview with #S-100 regarding transferring for this resident, they said the resident required extensive assistance with transferring/mobility, using a specific device. They also said that this resident requires assistance with transfers and is unable to ambulate. The inspector spoke with #S-101 who stated that resident #022 requires a specific device for all transfers and is non-ambulatory. #S-101 said that all information regarding their toileting needs and transferring needs would be found in the care plan.

During an interview with #S-102 regarding this resident's needs for locomotion, they identified that resident #022's status in terms of locomotion, as their needs have recently changed and that the care plan should have been updated to indicate this change and that they would update accordingly. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #022.

Inspector spoke with #S-103 to confirm the use of a specific feature of their wheelchair for this resident. #S-103 told the inspector that the resident's care plan will identify the use of this specific feature and will note the purpose of the feature. #S-103 and the inspector reviewed the care plan together, and identified that the care plan only stated "Total Assistance in wheelchair". #S-103 confirmed with #S-102 that the specific feature was for comfort measures. #S-103 then updated the care plan. In a conversation with #S-103 regarding this resident's chair and specific feature they said that this resident has been in the chair since their admission; and that their chair with specific feature is not considered a PASD or a restraint as long as the POA agrees and it's in their care plan,

which should identify why this resident required the chair with specific feature.

During a conversation with #S-102 regarding the chair and specific feature for resident #022 they said that this resident requires the specific feature for comfort and the resident has a device attached for this purpose. This information was not captured on resident #022's care plan.

#S-102 said that in terms of care planning for a chair with specific feature, care plans are a shared document, but typically each discipline is responsible for inputting data. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #021.

Inspector #612 reviewed resident #021's health care record. Inspector noted in resident's care plan under the hygiene/grooming focus, there were interventions related to the use of the resident's dentures.

Inspector #612 observed resident #021 June 3, 2015. During breakfast and lunch time the resident was not wearing their dentures according to the specific instructions in the care plan.

Inspector #612 spoke with #S-103 who indicated why the resident did not wear their dentures according to the specific instructions of the care plan. Both #S-101 and #S-104 confirmed that the resident does not wear the dentures according to the care plan.

Inspector #612 reviewed resident #021's health care record. The resident's care plan identified, the intervention 'encourage the use of device to right hand every shift'.

The inspector observed resident #021 on multiple occasions during the inspection to have a device applied to both the left and right hands.

Inspector interviewed #S-104 who confirmed that staff apply a device on both of resident's hands. [s. 6. (1) (c)]

4. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Inspector #593 observed May 28, 2015, bed rails in the up position for resident #011. During the remainder of the inspection, the inspector observed on numerous occasions the bed rails to be in the down position. A review of the resident's care plan found an intervention documenting- bed rails up when in bed.

During an interview with Inspector #593 June 4, 2015, #S-105 confirmed that resident #011 does use bed rails when they are getting out of bed. They also said that the bed rails are always in the up position even during the day.

During an interview with Inspector #593 June 4, 2015, #S-106 confirmed that resident #011 does use bed rails. #S-106 further added that specific interventions are in place related to the bed rails for resident #011. #S-106 advised that the resident uses the bed rails when they first get out of bed in the morning.

During an interview with Inspector #593 June 5, 2015, the Acting ADOC confirmed that the care plan for this resident with regards to bed rail use should have been more personalized to capture the specific intervention.

A review of the home's policy: Bedside Rails- Use of, dated September 6, 2015 documented to ensure the care plan is updated to reflect the use of bedrails and the rationale. [s. 6. (1) (c)]

5. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

A review of the diet sheet located in one of the dining rooms May 28, 2015, found that resident #025 was required to have a texture modified diet.

A review of resident #025's physician's orders, found that the resident was to receive a regular textured diet. A review of resident #025's care plan, found that the resident was to receive a regular textured diet.

During an interview with Inspector #593, June 4, 2015, #S-107 said that there was a diet sheet located in the servery of each dining room and staff will refer to this so they know the dietary requirements for each resident.

During an interview with Inspector #593, June 4, 2015, #S-108 said that there was a resident diet list that is pulled out and referred to for every meal. If there are any changes to a resident's dietary requirements, then this list is updated very quickly so that staff are aware of the changes. [s. 6. (1) (c)]

6. The licensee has failed to ensure that the resident`s substitute decision maker (SDM), has been provided the opportunity to participate fully in the development and implementation of the plan of care.

During an interview with Inspector #593, resident #003's SDM indicated that they were not notified when there was a change in the resident's medication.

Inspector #575 reviewed the resident's health care record. The inspector noted that in March, 2015 the medication ordered for the resident was increased.

The inspector interviewed three registered staff #S-109, #S-110 and #S-111 who all confirmed that when there are changes to a resident's medication that staff are to notify the resident's SDM and document in the progress notes that the SDM was notified. #S-111 reviewed the resident's progress notes and confirmed that there were no notes to indicate that the SDM was notified of the medication dose increase made in March, 2015.

During an interview with Inspector #575, the resident's SDM indicated that they were present in the home when a staff member was administering medication to resident #003 when they noticed an extra pill given to the resident. The SDM stated that they questioned the dosage and that is when the staff advised the SDM that there was a change in the resident's medications. [s. 6. (5)]

7. 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.

Inspector #612 reviewed resident #021's health care record. In the resident's care plan, the inspector noted the intervention to 'ensure bed device is on at all times, even if resident is not in their room as per POA'.

Inspector #612 observed resident's bed device was not on, June 4, 2015, when resident was in their bed. Inspector observed co-resident walk up to resident #021's room and enter resident's room. Inspector then noted two staff members walking up the hallway.

They walked past resident's room, noted that co-resident was in resident #021's room and escorted co-resident out of the room. #S-100 proceeded to turn on the resident's bed device.

Inspector #612 spoke with #S-100, #S-112 and #S-103 who confirmed that the resident's bed device should be on at all times. [s. 6. (7)]

8. The licensee has failed to ensure that the plan of care is revised when the resident's care needs change.

Inspector #543 reviewed resident #022's most recent Care Conference which identified that the resident's mobility has decreased since admission; and as a result, different interventions are required for transferring and mobility.

During an interview with the home's physiotherapist regarding this resident's need for different mobility aids, they stated that this resident's status in terms of using a different mobility aid is a recent change, the resident's mobility has decreased and requires a different mobility aid. They reported that in terms of care planning typically each discipline is responsible for updating any resident care need changes. They confirmed that the care plan should have been updated to indicate this change, and stated that they should have made the change as the resident's needs changed. [s. 6. (10) (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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's Falls Prevention and Management Program was complied with.

Inspector #543 reviewed the home's policy-Falls Prevention and Management Program. This policy stated that registered staff duties included but were not limited to notifying the attending physician and family of the fall and to notifying the DOC/delegate if the fall resulted in significant injury, as this must be reported to the MOHLTC via the critical incident report system.

During a conversation with the Administrator regarding an incident that occurred related to resident #022 who fell during a transfer, they said that the DOC was not informed until five days after the incident that there was an injury involved in the fall and that the resident actually fell during a transfer. The Administrator also confirmed that this was the reason why the critical incident was not submitted to the MOHLTC until five days after the incident, otherwise it would have been submitted immediately. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the home's 'Continence Care Program' policy was complied with.

Inspector #612 reviewed the home's policy titled 'Continence Care Program'. This policy stated that the RN and RPNs roles and responsibilities are to complete a Bowel and Bladder Continence Assessment upon admission, quarterly and with any change in condition that affects continence.

The inspector reviewed resident #011's health care record and identified that this

resident was admitted to the home in 2014. The assessment tab was reviewed in PointClickCare (PCC) and the inspector was unable to locate a completed Bladder and Bowel Continence Assessment since resident's admission. Therefore, as per the documentation, this resident was not provided a Bladder and Bowel Continence Assessment on admission, or quarterly.

Additionally, the inspector spoke with the Acting DOC and #S-116 who confirmed that Bowel and Bladder Continence Assessments are to be performed on admission as well as quarterly. They confirmed that these assessments would be documented in PCC under the 'Assessments' tab. [s. 8. (1) (b)]

3. The licensee has failed to ensure that the home's least restraint policy was complied with.

During the course of the inspection, inspector #612 observed resident #031 at the nurses’ station in their chair pulling their restraint device over their head. Staff on the unit were notified, the restraint was released and there was no injury to resident.

Inspector reviewed the home's ‘Least Restraint’ Policy. The policy stated that ‘a member of the registered nursing staff (RN or RPN) will reassess the residents’ condition and the effectiveness of restraining at least every 8 hours while the restraint is in use. This will be documented on the Medication Administration Record (MAR)’.

Inspector #612 reviewed resident's MAR for a two month period and was unable to find any documentation to indicate that the resident’s condition and the effectiveness of restraining was assessed at least every 8 hours while the restraint was in use.

Inspector #612 reviewed resident's MAR with #S-117 who confirmed that there was nothing on resident #031's MAR requiring registered staff to document every 8 hours or more often if required. [s. 8. (1) (b)]

4. The licensee has failed to ensure that the home's policy titled 'Expiry and Dating of Medications' and 'Medication Storage' was complied with.

Inspector #575 observed the medication storage cart in the Whitewater home area with #S-110. The staff member said that insulin is to be stored for 30 days in the medication cart once removed from the fridge and that staff are to label the insulin with the date when removed from the fridge. The inspector observed and the staff member confirmed

two insulin pens in the cart not labelled with the date they were opened. The home's policy titled 'Expiry and Dating of Medications' dated 01/14 indicated that designated medications (i.e eye drops, insulin) must be dated when opened and removed from stock when expired and to refer to the recommended expiry dates once product is opened.

Inspector #575 observed the refrigerators in all medication storage areas and the fridge where the vaccines are stored. The following lists the home area, interviews with staff, observations of the fridge and an audit of all temperature records:

In a specific home area:
#S-118 said that they would normally take the temperature first thing in the morning but that they had not done taken it yet today. The inspector noted the following in the fridge: pudding, insulin, fruit bowl, Mantoux vaccine. The temperature records were obtained and the inspector reviewed and determined that the temperature had not been recorded since February 4, 2015 and previous to that, the temperature was only taken on January 2, 2015.

In a specific home area:
#S-119 said that the full time staff are to record the temperatures and that they are casual staff therefore they had not taken any temperatures. The inspector noted the following in the fridge: pudding, insulin, peg lyte and boost. The temperature records were obtained for April, May and June, 2015 and the inspector reviewed and determined the following: in April only 12/60 temperatures were recorded, in May only 23/62 temperatures were recorded and in June (to June 4) only 2/8 temperatures were recorded.

In a specific home area:
#S-120 said that fridge temperatures are to be taken once per shift by the RPN. The inspector noted the following in the fridge: pudding, Nutella, chocolate, fruit rite, beer, and insulin. The temperature records were obtained for May and June, 2015 and the inspector reviewed and determined the following: in May only 54/62 temperatures were recorded and in June only 6/9 temperatures were recorded.

In a specific home area:
#S-110 said that the temperatures do not need to be taken for the refrigerators in each home area because there are no medications that need to be monitored and that the only refrigerator that is monitored is the vaccine fridge. The inspector observed insulin and pudding in the fridge. The temperature records were obtained for May and June, 2015

and the inspector reviewed and determined that the the temperatures were inconsistently recorded and no temperature had been recorded since March 24, 2015.

The inspector reviewed the vaccine fridge temperature records for April and May 2015 and noted that in April the temperature was not recorded on six occasions and in May the temperature was not recorded on 12 occasions.

During an interview, #S-109 said that the vaccine fridge temperatures are taken twice daily and they were not sure about each medication room fridge. Another staff member, #S-121 said that RPNs are responsible for their own medication room fridge and that RNs are responsible for the vaccine fridge.

The inspector interviewed the Acting DOC regarding the monitoring and recording of fridge temperatures. The Acting DOC said that temperatures do not need to be monitored for each fridge in the home areas because they do not contain medications that need to be monitored. Additionally, they stated that temperatures are required to be monitored only for the fridge with the vaccines and are to be recorded twice daily.

The inspector reviewed the home's policy titled 'Medication Storage' dated 01/14 which stated under section C (the refrigerator) to store all medications requiring refrigeration in a separate refrigerator upon receipt, not with food or laboratory specimens. This fridge must be locked in the medication room. Narcotic/controlled medications require double locking. Maintain temperature between 2 and 8 degrees Celcius. Ensure temperature is within range whenever medication is removed or added to the refrigerator. Avoid measuring temperature of fridge after door has been open for a period of time. The refrigerator used to store vaccines will be monitored regularly and temperatures documented as per Public Health Directives. Store external medications separately from internal medications. Do not store medications in the fridge door because temperatures are not consistently in range in this area.

The inspector noted that temperatures were not recorded or monitored consistently and food was noted to be stored with medications. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all required policies and programs as per the LTCHA, are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents requiring texture modified diets and thickened fluids were provided with food and fluids that were safe.

During the lunch service in one of the home's units May 25, 2015, Inspector #593 observed two main choices available for residents including a hot pork sandwich with salad or a cheddar cheese, fruit and banana loaf plate. For those residents requiring a pureed diet, both meal options were available in pureed texture however for those residents requiring a minced textured diet, the regular cheddar cheese, fruit and banana loaf plate was provided to these residents if they chose this option. This second meal option was not observed to be minced in texture. Residents requiring a minced textured diet as per the diet sheets were observed to be provided a cheese, fruit and banana loaf plate.

During the lunch service in one of the home's units May 25, 2015, Inspector #593 observed two dessert choices available for residents including butter tarts or grapes. For those residents requiring a minced textured diet, the regular butter tart was provided. This was confirmed by #S-103 who said that the regular butter tart was provided for residents requiring a minced textured diet. Residents requiring a minced textured diet as per the diet sheets were observed to be provided a regular butter tart.

During the lunch service in one of the home's units June 2, 2015, Inspector #593 observed two main choices available for residents including beef vegetable goulash with salad or perogies with onion and bacon with salad. It was observed that both options were available in pureed texture however only the beef vegetable goulash was observed in the minced texture. During an interview with Inspector #593, #S-122 advised that they were unsure if the perogies were suitable for residents requiring a minced textured diet. At this time, he asked #S-103, who responded, yes, we just serve them without bacon. Residents requiring a minced textured diet as per the diet sheets were observed to be provided regular perogies.

During the lunch service in one of the home's units June 2, 2015, Inspector #593 observed resident #021 provided with two beverages, both of which were thin consistency. The diet sheet for this resident documents thickened fluids. Residents #006 and #007 were observed to be provided thickened fluids however the fluids were thickened by the PSW, who was observed to prepare the fluids without measuring the amount of thickener or consult a recipe.

During the dinner service in one of the home's units June 2, 2015, Inspector #593 observed residents #005 and #010 to be provided a thickened cranberry juice. It was also observed that the residents were consuming these beverages through a straw. The thickened cranberry juice observed on the drinks trolley was nectar thick consistency. As per residents #005 and #010 physician's orders, they are required to have different consistency of fluids. #S-123 confirmed that residents #005 and #010 received the nectar thickened cranberry juice.

During the lunch service in one of the home's units June 3, 2015, Inspector #593 observed resident #009 offered the choice of hash browns or mashed potato, the resident was also observed to be provided regular bologna with their meal. A review of the physician's orders for this resident found that the resident is required to have a texture modified diet. Resident #005 was observed to be provided three thickened beverages during this lunch service, two of the beverages were observed to be nectar thick consistency. A review of the physician's orders for this resident found that the resident is required to have a different consistency of fluids. The two menu choices during this lunch service were fried bologna with hash browns and peas or breaded fish burger with coleslaw. It was observed that there was no minced option of the fish burger available and as confirmed by dietary staff, the regular fish burger was considered suitable for residents requiring a minced diet.

During an interview with Inspector #593 June 4, 2015, #S-124 said that nursing staff are responsible for preparing the thickened fluid in the dining room and there is a recipe posted on the wall next to the servery. They further stated that they do have some commercially thickened fluids, however these are only available in nectar thick consistency. #S-124 also confirmed that staff should not be adding thickener to pre-thickened fluids as they do not have guidelines for this and the result is usually a lumpy product. They also advised that they have previously encountered some issues with the provision of thickened fluids in the home. #S-124 was informed of the following items provided to residents requiring a minced textured diet: breaded fish burger, perogies and butter tart. #S-124 advised that with the fish burger, staff should have cut up the fish and added extra sauce to make it soft, with the perogies, the staff should have cut up the perogies and the butter tart is not suitable for residents requiring a minced textured diet.

A review of the homes Policy: Diet Order Glossary dated April 25, 2014 found that minced textured diets are to be minced, mashed or soft in texture and honey thickened fluids are too thick to be taken through a straw.

During the inspection, Inspector #593 observed on numerous occasions, residents requiring texture modified foods and fluids, provided foods and fluids that were not the correct consistency according to their diet order. Furthermore the minced diets provided did not align with the home's policy or as per the home's Registered Dietitian. [s. 11. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that residents requiring texture modified meals are provided the appropriate texture for their diet order and the textures are provided in accordance with best practice guidelines, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Findings/Faits saillants :

1. Inspector #575 observed resident #003 in bed on multiple occasions with the rails up. The inspector reviewed the resident's health care record and noted that bed rails are to be up when the resident is in bed and that they are used daily for transfer and mobility. #S-113 and #S-114 confirmed to the inspector that the resident used the rails for transfers and mobility.

The inspector asked the Acting DOC when bed rails are used, if these residents have been assessed and their bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident. The Acting DOC provided the inspector with a document titled 'St. Gabriel's Villa Bed Entrapment Risk Assessment' dated August 30, 2012. The document indicated that the home had 128 beds and showed the following: the beds mostly consisted of JOERN (Model ECS Easy Care 5) with the exception of four residents which have JOERNS bariatric beds (model XT Ultra Care); and out of 128 there are 123 Geo foam, two air and four bariatric foam mattresses. The audit included 12 JOERNs Model ECS Easy Care 5 beds with Geo Tech regular foam mattresses and all four Bariatric XT Ultra Care beds with Geo Tech regular bariatric foam mattress. The test was completed using a device from the National Safety Technologies. The assessment indicated that seven zones of entrapment had been identified through the Health Canada Guidance document and that there were dimensional limits for zones 1 through 4. The assessment indicated that zones 1-4 passed on the 12 beds tested. Resident #002's bed was not part of the assessment.

Inspector #575 interviewed #S-115 regarding the bed system assessment. #S-115 indicated that the bed systems were assessed at one time and then confirmed that only 12 beds were assessed plus the four bariatric beds. #S-115 said that all beds were the same, therefore a random audit of 12 beds was completed for entrapment (not every bed system was audited). The inspector inquired if the home had reviewed height and latch reliability and they indicated that there had not been a home wide assessment specifically for height and latch reliability. #S-115 indicated that when something is broken or needs to be fixed the staff would complete a work order and the maintenance department would fix in 1-2 days. They further said that if there was a safety risk to the residents, maintenance department would be called immediately to deal with the situation.

The inspector interviewed the Acting DOC regarding resident and bed system assessment. The Acting DOC said that the resident assessment related to bedrails is based on the admission assessment, the level of care required (is the resident

independent or do they require assistance), whether the rails are used for safety or transferring and it is based on what the resident would prefer. They further indicated that the home did not assess all beds because the beds were all the same and they were purchased based on the Health Canada Guidelines. The inspector asked about the requirement to ensure that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment and the staff member indicated that the measures to reduce entrapment included the bed entrapment risk assessment completed on the 12 + 4 beds by ensuring they met the safety requirements. The staff member also said that there was no specific assessment for height and latch reliability and staff are to report to maintenance regarding any issues.

The inspector reviewed a memo from the Ministry of Health and Long-Term Care dated August 21, 2012 sent to all Long-Term Care (LTC) Home Administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document outlined entrapment testing zones, required tools (cone and cylinder, spring scale), side rail height, side rail latch reliability requirements and test methods, mattress compatibility information, other hazards, etc.

Therefore, the licensee has failed to ensure that where bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize the risk to the resident, that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment and that other safety issues related to the use of bed rails are addressed, including height and latch reliability. [s. 15.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where bed rails are used, every resident is assessed and his or her bed system evaluated in accordance with evidence-based practices and that steps are taken to prevent resident entrapment and that other safety issues related to the use of bed rails are addressed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The Licensee has failed to ensure that the persons who have received training under subsection (2) receive retraining in the long-term care home's policy to promote zero tolerance of abuse and neglect of residents annually.

A review of the home's 2013 Elder Abuse education records for 2013 found that 25 out of 178 staff members in the home completed the education in 2013.

A review of the home's 2014 Elder Abuse education records for 2014 found that 68 out of 178 staff members in the home completed the education in 2014.

During an interview with Inspector #593 June 5, 2015, the acting ADOC confirmed that the education records provided were accurate as to the level of attendance.

A review of the home's policy: Zero Tolerance of Abuse and Neglect under Education and Training found that the policy on zero tolerance of abuse and neglect will be reviewed with each new employee during orientation and annually thereafter. [s. 76. (4)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

During the course of the inspection, inspector #612 observed resident #031 at the nurses' station in their chair pulling their restraint device over their head. Staff on the unit were notified, the restraint was released and there was no injury to the resident.

Inspector #612 interviewed #S-109 and #S-117 who said that there is no responsibility of the registered staff to reassess the resident and the effectiveness of the restraint, every 8 hours or more if required and the PSWs would notify the registered staff if there were any concerns.

Inspector #612 interviewed the acting DOC and #S-125 who said that registered staff are responsible to monitor the resident and document every 8 hours the assessment of the resident and the effectiveness of the restraint. This information would be documented in the resident's MAR.

Inspector #612 reviewed resident #031's health care record. Inspector noted that there was no documentation of a physician or a registered nurse in the extended class or a member of the registered nursing staff to indicate that they had reassessed resident and the effectiveness of the restraining for resident #031, at least every 8 hours. [s. 110. (2) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all residents with a physical restraint applied, are reassessed as per the regulations at least every eight hours by a physician, registered nurse in the extended class or member of the registered nursing staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart,
i. that is used exclusively for drugs and drug-related supplies,
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 (e.g. expiration dates, refrigeration, lighting).

Inspector #575 observed resident #002's bathroom cupboard and noted several medications. The inspector reviewed resident #002's health care record and noted an order to discontinue one of these medications several months earlier. Both of these medications were observed in the resident's bathroom cupboard, were discontinued and there was no physician's order for the resident to have medications at their bedside. The inspector and #S-110 observed resident #002's bathroom and the medications. #S-110 indicated that the medications should not be stored in the resident's room and confirmed that there was no current order for these medications.

During the initial tour of the home on May 25, 2015, Inspector #543 observed medicated shampoo in the tub area for resident #005. Inspector #575 again observed the same medicated shampoos on June 3, 2015. One of the medicated shampoos was dated several months earlier and had expired. During an interview #S-110 said that medicated shampoos should be stored in the medication cart, removed for use and put back in the

cart when not in use. [s. 129. (1) (a)]

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

Inspector #575 observed a home area medication storage area with #S-110. #S-110 said and the inspector observed that controlled substances were stored in a separate locked area in the medication cart. #S-110 said that the emergency supply of controlled substances were stored in a second home area medication storage area and was only accessible by the RN designated to that area.

The inspector observed the second home area medication storage area with #S-121. #S-121 said and the inspector observed that the controlled substances were single locked in a stationary cupboard in the locked area (as opposed to double-locked in the locked area). [s. 129. (1) (b)]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect was complied with.

A Critical Incident (CI) was reported to the Director of the Ministry of Health and Long-Term Care (MOHLTC) in relation to alleged physical abuse by a staff member toward a resident in the home. The resident reported that the staff member physically and verbally abused them. The home's investigation resulted in the allegations to be unfounded.

The resident was unable to name the staff member that they were accusing, however based on a description they were able to narrow down to one PSW who was working when the abuse was alleged to have happened. As part of the home's investigation, this PSW, as well the on duty RN were interviewed. During an interview with Inspector #593 June 5, 2015, the Administrator said that the DOC interviewed the PSW and the RN as part of the investigation, however this information was not documented.

A review of the home's policy: Zero tolerance of Abuse and Neglect dated September 17, 2013 found that the investigation if warranted will lead to creation of a confidential file of the report of the investigation, including all statements and other documentation related to, or generated by the investigation. [s. 20. (1)]

WN #9: 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 has his or her personal items, including personal aids such as dentures, glasses and hearing aids labelled within 48 hours of admission and of acquiring, in the case of new items.

On May 25, 2015 during a tour of the home, Inspector #593 observed two unlabelled 'puffs' hanging and making contact together in the shower room in a specific home area.

On June 3, 2015, Inspector #575 observed the tub and shower rooms on all home areas. In the specific home area, the inspector observed two unlabelled 'puffs' hanging and making contact together and another 'puff' hanging on a separate hook. The inspector noted that all three 'puffs' were not labelled. Inspector #544 interviewed #S-100 and #S-104 regarding the unlabelled items. Both staff members said that they did not know who the 'puffs' belonged to, that they never used them, and that they have been hanging there for at least a couple of months.

Additionally, in a specific home area, Inspector #575 observed one unlabelled stick of deodorant on the sink counter in the tub area. The inspector observed the tub area with #S-126. The staff member said that they did not know who it belonged to and that it had been there for a long time. The inspector asked what the process was for labelling residents' personal items and #S-126 indicated that resident's items should be placed in the resident's labelled basket and that some staff label individual items however not all staff participate in this practice.

The inspector interviewed the Acting DOC regarding the process for labelling residents' personal items. The staff member indicated that when a resident is admitted or when new articles are brought into the home, the items are to be brought to laundry to be labelled. The inspector asked about resident personal items such as deodorant and the staff member stated that they would be placed in the residents' labelled drawer or basket, that all items are not necessarily labelled however they are to be placed back in the resident's bin after use. [s. 37. (1) (a)]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On June 1, 2015, resident #002 said to Inspector #575 that during the day, the staff advise them of activities that are occurring. The resident did not recall if the home offered activities during the evening or weekends.

The inspector interviewed #S-127 regarding the home's activity program. #S-127 said that during the evening and weekends there is only one activity staff member present and if they are absent for any reason (ie holidays) there is no replacement staff. They said that there is an evening activity on each home area each week that all residents are welcome to attend however some residents do not think they are able to attend an activity if it is scheduled in another home area. During the evening and weekend programs, the activity staff are not able to provide assistance to all residents because they are the only staff available and do not have time. #S-127 said that they encourage

the clinical staff to assist with porting residents to the evening and weekend programs however they reported that the clinical staff often do not have time.

#S-128 told the inspector that the home utilized 'Activity Pro' for documenting residents participating in activities. The inspector reviewed March, April and May 2015 activity records for resident #002. The inspector reviewed the records with #S-127. #S-127 said that the activities that are listed on the resident's activity record are the activities that the resident would typically attend and that not all activities offered are on the record. The staff also noted that if a resident chooses not to attend certain activities, it is not always reflected in the statistics and that sometimes activities might change from the schedule and changes are communicated via the whiteboard to residents. The March and May records indicated that the resident participated in activities on the weekends, however there was no record of the resident participating in the evening activities. The April record indicated that the resident participated in activities on the weekends and participated in one evening movie night.

The inspector reviewed resident #002's care plan. The resident's care plan indicated that staff are to encourage participation in social gatherings and group programs and listed several activities that the resident enjoys. The resident was also dependent in their wheelchair and required one staff to porter the resident for mobility.

On June 3, 2015, the inspector noted an evening activity (movie night) scheduled in a specific home area at 1815 hours. The inspector observed resident #002 in their room at approximately 1820 hours. The inspector asked the resident if any staff advised them of the activity. The resident stated that sometimes they will advise them but that no one advised them about the movie night. The inspector advised that the movie was on a different floor. The resident indicated that if the activity was on their floor that the staff would assist them. The resident stated that they overheard residents talking about the movie but that now it is too late for them to attend and that they were not provided assistance to attend.

Although the home offered activities during the evenings and weekends, the inspector noted and confirmed with the activity staff that not all residents are provided assistance and support to attend these activities. [s. 65. (2) (f)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(c) includes alternative choices of entrees, vegetables and desserts at lunch and dinner; O. Reg. 79/10, s. 71 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's menu cycle includes alternative choices of desserts at lunch and dinner for residents requiring a texture modified diet.

During the lunch service in one of the home's units May 28, 2015, Inspector #593 observed two dessert options available for residents including grapes or a butter tart. The regular butter tart was provided to residents on both a regular and minced textured diet and a pureed butter tart was available for residents requiring a pureed diet however the grapes were only available for residents receiving a regular diet as confirmed by #S-103. Residents requiring a minced or pureed textured diet were only provided with one dessert option during this lunch service.

During the lunch service in one of the home's units June 2, 2015, Inspector #593 observed two dessert options available for residents including peach passion mousse or a banana. The peach passion mousse was suitable for all texture modified diets however the banana was served whole and therefor only suitable for residents receiving a regular textured diet. Residents requiring a minced or pureed textured diet were only provided with one dessert option during this lunch service. [s. 71. (1) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program.

On May 29, 2015, Inspector #575 observed medication administration in one of the home's units by #S-111 to two residents. During the first administration, the inspector observed the staff member obtain a specific sample from the resident and subsequently administered the medication to the resident. No handwashing was observed before or after administration. During the second administration, the inspector observed the staff member obtain a specific sample from the resident and subsequently administered the medication. Handwashing was only observed after administration.

On June 3, 2015 Inspector #575 observed medication administration in one of the home's units by #S-110. The inspector observed #S-110 administer medication to five residents. During the first administration, a specific sample was taken from the resident and subsequently the medication was administered. No handwashing was observed before or after administration. Two other residents received their oral medication in the hallway and another resident received oral medication in their room. No handwashing was observed. During the last administration, the inspector observed the staff member administer eye drops to a resident and no handwashing was observed before or after administration.

The inspector reviewed the home's 'Hand Hygiene' policy. The policy indicated that staff are to perform hand hygiene before initial resident/resident environment contact, before aseptic procedure, after bodily fluid exposure, and after resident/resident environment contact.

The inspector interviewed the Acting DOC regarding the expectation for hand hygiene. The acting DOC said that staff are to perform hand hygiene after any hands on contact with residents and indicated hand hygiene would be expected after taking specific samples from residents and administering medications. [s. 229. (4)]

Issued on this 27th day of August, 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) :	GILLIAN CHAMBERLIN (593), LINDSAY DYRDA (575), SARAH CHARETTE (612), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2015_380593_0015
Log No. / Registre no:	S-000832-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 21, 2015
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.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	

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) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_282543_0029, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that every individual plan of care is reviewed by a member of the registered nursing staff to ensure that the plan of care for all residents provides clear directions to staff and others who provide direct care to the resident and revised.

This review is to be completed by August 21, 2015.

Grounds / Motifs :

1. During an inspection completed December 30, 2014 under inspection 2014_282543_0029, a compliance order was issued pursuant to LTCHA, 2007 S.O. 2007, c.8, s.6. (1) (c) the licensee failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident.

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

A review of the diet sheet located in one of the dining rooms May 28, 2015, found that resident #025 was required to have a texture modified diet.

A review of resident #025's physician's orders, found that the resident was to

receive a regular textured diet. A review of resident #025's care plan, found that the resident was to receive a regular textured diet.

During an interview with Inspector #593, June 4, 2015, #S-107 said that there was a diet sheet located in the servery of each dining room and staff will refer to this so they know the dietary requirements for each resident.

During an interview with Inspector #593, June 4, 2015, #S-108 said that there was a resident diet list that is pulled out and referred to for every meal. If there are any changes to a resident's dietary requirements, then this list is updated very quickly so that staff are aware of the changes. [s. 6. (1) (c)] (593)

2. The licensee has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Inspector #593 observed May 28, 2015, bed rails in the up position for resident #011. During the remainder of the inspection, the inspector observed on numerous occasions the bed rails to be in the down position. A review of the resident's care plan found an intervention documenting- bed rails up when in bed.

During an interview with Inspector #593 June 4, 2015, #S-105 confirmed that resident #011 does use bed rails when they are getting out of bed. They also said that the bed rails are always in the up position even during the day.

During an interview with Inspector #593 June 4, 2015, #S-106 confirmed that resident #011 does use bed rails. #S-106 further added that specific interventions are in place related to the bed rails for resident #011. #S-106 advised that the resident uses the bed rails when they first get out of bed in the morning.

During an interview with Inspector #593 June 5, 2015, the Acting ADOC confirmed that the care plan for this resident with regards to bed rail use should have been more personalized to capture the specific intervention.

A review of the home's policy: Bedside Rails- Use of, dated September 6, 2015 documented to ensure the care plan is updated to reflect the use of bedrails and the rationale. [s. 6. (1) (c)] (593)

3. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #021.

Inspector #612 reviewed resident #021's health care record. Inspector noted in resident's care plan under the hygiene/grooming focus, there were interventions related to the use of the resident's dentures.

Inspector #612 observed resident #021 June 3, 2015. During breakfast and lunch time the resident was not wearing their dentures according to the specific instructions in the care plan.

Inspector #612 spoke with #S-103 who indicated why the resident did not wear their dentures according to the specific instructions of the care plan. Both #S-101 and #S-104 confirmed that the resident does not wear the dentures according to the care plan.

Inspector #612 reviewed resident #021's health care record. The resident's care plan identified, the intervention 'encourage the use of device to right hand every shift'.

The inspector observed resident #021 on multiple occasions during the inspection to have a device applied to both the left and right hands.

Inspector interviewed #S-104 who confirmed that staff apply a device on both of resident's hands. [s. 6. (1) (c)]
(612)

4. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to resident #022.

Inspector spoke with #S-103 to confirm the use of a specific feature of their wheelchair for this resident. #S-103 told the inspector that the resident's care plan will identify the use of this specific feature and will note the purpose of the feature. #S-103 and the inspector reviewed the care plan together, and identified that the care plan only stated "Total Assistance in wheelchair". #S-103 confirmed with #S-102 that the specific feature was for comfort measures. #S-103 then updated the care plan. In a conversation with #S-103 regarding this resident's chair and specific feature they said that this resident has been in the

chair since their admission; and that their chair with specific feature is not considered a PASD or a restraint as long as the POA agrees and it's in their care plan, which should identify why this resident required the chair with specific feature.

During a conversation with #S-102 regarding the chair and specific feature for resident #022 they said that this resident requires the specific feature for comfort and the resident has a device attached for this purpose. This information was not captured on resident #022's care plan.

#S-102 said that in terms of care planning for a chair with specific feature, care plans are a shared document, but typically each discipline is responsible for inputting data. [s. 6. (1) (c)]

(543)

5. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to resident #022 specifically related to transferring and/or mobility.

Inspector #543 reviewed resident #022's most recent Care Conference notes, which identified that this resident's mobility has decreased since admission, and now requires a specific device for transfers.

Inspector #543 reviewed this resident's most recent care plan which identified mobility goals and assistance required to achieve this. In terms of transferring, this resident's care plan identified that interventions would be addressed in the mobility section of the care plan. The mobility section of this resident's care plan did not identify this.

Inspector reviewed this resident`s most recent RAP triggers related to ADL Functional Rehabilitation Potential which identified that the resident requires assistance for locomotion on and off unit.

In an interview with #S-100 regarding transferring for this resident, they said the resident required extensive assistance with transferring/mobility, using a specific device. They also said that this resident requires assistance with transfers and is unable to ambulate. The inspector spoke with #S-101 who stated that resident #022 requires a specific device for all transfers and is non-ambulatory. #S-101

said that all information regarding their toileting needs and transferring needs would be found in the care plan.

During an interview with #S-102 regarding this resident's needs for locomotion, they identified that resident #022's status in terms of locomotion, as their needs have recently changed and that the care plan should have been updated to indicate this change and that they would update accordingly. [s. 6. (1) (c)] (543)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 21, 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 21st day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gillian Chamberlin

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