Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 31, 2016	2016_320612_0007	005679-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15 Chelmsford ON P0M 1L0

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

SARAH CHARETTE (612), ALAIN PLANTE (620), FRANCA MCMILLAN (544)

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): March 7-11 and 14-18, 2016

The Inspectors also inspected a Follow Up, and a Complaint, both related to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Unit Assistant, the Manager of Environmental Services, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Activity Lead, Human Resource Coordinator, Staff Scheduler, Food Services Manager (FSM), the Registered Dietitian (RD), residents' family members and residents.

The Inspector(s) conducted a daily walk through of common areas, observed the provision of care to residents, observed staff to resident interactions, reviewed various policies and procedures, reviewed clinical records, care plan audits, staff schedules and a critical incident report.

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
Residents' Council
Responsive Behaviours
Sufficient Staffing

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

- **11 WN(s)**
- **5 VPC(s)**
- **5 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 26. (3)	CO #001	2015_264609_0059	544

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure the plan of care for each resident set out the planned care for the resident.

During the RQI, resident #005 was observed to have an upper quarter bed rail engaged in the guard position on March 08, 2016.

Further observations by Inspector #620 on March 10, 2016, at 1420 hours, revealed that resident #005 was in bed with both upper quarter bed rails engaged in the guard position.

A review of resident #005's plan of care revealed no focus, goals or interventions related to the use of the upper quarter bed rails.

Inspector #620 reviewed the resident's health care record and noted that the PSWs had charted in Point of Care (POC) over a 30 day period that the bed rails were utilized by resident #005 for bed mobility.

Inspector #620 interviewed RPN #110 who stated that they were unaware if the bed rails for resident #005 had been included in the care plan. The RPN #110 stated that it was the home's expectation that where bed rails were used, the number and use of the bed rails would be included in the care plan, and this had not occurred.

Inspector #620 interviewed the DOC who confirmed that resident #005 had the upper quarter bed rails engaged in the guard position. They also confirmed that the bed rails were intended to provide resident #005 with improved bed mobility and comfort. Inspector #620 and the DOC reviewed the resident's care plan. The DOC indicated that PSW staff were expected to review the care plan to determine the use of bed rails. The DOC confirmed that the care plan had not indicated any information related to the use of bed rails, and should have. [s. 6. (1) (a)]

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

During stage one of the RQI, Inspector #612 interviewed resident #011's family member. They identified that they were concerned that resident #011 was not receiving the assistance they required.

Inspector #612 observed resident #011 during a meal service on March 10, 2016, and another meal service on March 14, 2016. The Inspector noted that the resident did not receive any assistance during the meal.

The Inspector reviewed the resident's care plan, which stated under the eating focus that the resident required a specific level of assistance from staff.

The Inspector interviewed the Registered Dietitian (RD) who stated that resident #011 had been assessed by a member of the multidisciplinary team and the preference was for staff to provide a specific level of assistance. The RD stated that the resident would refuse to allow staff to assist them.

The Inspector interviewed PSW #127, RPN #105, and RN #106 who all stated that resident #011 would refuse a specific level of assistance from staff and staff would provide assistance only if they noticed the resident was having difficulty they would provide a certain level of assistance.

RPN #105 confirmed that the plan of care did not provide clear direction to staff in

regards to resident #011's level of assistance with eating. [s. 6. (1) (c)]

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

During an interview with resident #003, they reported to Inspector #612 that the evening staff were rude to them while they provided care on a specific date. The resident was unable to provide the staff member's name.

A review of the home's investigation indicated that PSW #128 had responded to resident #003's call bell to provide assistance to the resident and that they had assisted the resident.

Inspector #612 reviewed the resident's care plan, which provided specific instructions to staff on how to provide care to the resident.

The Inspector interviewed PSW #128 who confirmed they had provided care to the resident on the specific date. They stated that they were unaware of the specific instructions provided in the residents care plan and confirmed they had not provided care as per the care plan.

The Inspector interviewed PSW #118 and RN #106 who confirmed that there were specific instructions in the plan of care in regards to the care resident #003 requires.

The Inspector interviewed the DOC who confirmed that it was the home's expectation that staff provided care to residents as indicated in their plan of care. [s. 6. (7)]

4. During stage one of the RQI, Inspector #612 interviewed resident #011's family member. They identified they were concerned resident #011 was not receiving the assistance they required.

Inspector #612 observed resident #011 during a meal service on March 10, 2016, and another meal on March 14, 2016. The Inspector observed that the resident was provided a specific food at both meals. The Inspector also observed that at the end of the meal service on March 10, 2016, all staff left the dining room. The resident was left alone in the dining room, eating their specific food for fifteen minutes. The Inspector noted the consistency of the food.

The Inspector reviewed the resident's most recent care plan and the following was listed:
- Ensure that the specific food provided to the resident was a specific consistency.
- Monitor closely during meals for signs identified in the care plan.

The Inspector interviewed the RD, who stated that they see the resident frequently along with another member of the multidisciplinary team. The resident had extensive interventions listed in their plan of care. The RD confirmed that staff were to ensure that the consistency of the specific food was appropriate as identified in the care plan. They also stated that the resident was to be closely monitored for the entire meal as indicated in their care plan.

The Inspector interviewed PSW #109, RPN #105 and RN #106 who confirmed that registered staff should have supervised the resident throughout the entire meal. RPN #105 stated that they had not made any adjustments to the resident's specific food and just served the food as it was prepared by the kitchen staff.

The Inspector interviewed the DOC who confirmed that the care was not provided to the resident as specified in the plan of care, and should have been. [s. 6. (7)]

5. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan of care was no longer necessary.

Inspector #612 reviewed resident #011's care plan, under a specific focus, which identified a specific level of assistance the resident required.

The Inspector reviewed the resident's health care record; specifically the PSW's charting in Point Of Care (POC) and noted that the staff had documented a different level of assistance then indicated in their care plan.

The Inspector interviewed PSW #126 and PSW #127 who confirmed that for approximately the last two months, the resident had required a different level of assistance than indicated in the care plan.

The Inspector interviewed RPN #105 and RN #106 who stated that they were not aware of the change in the resident's status. They reported that typically the PSW staff would notify the registered staff and they would update the resident's plan of care to reflect any changes.

The Inspector interviewed the DOC who confirmed that the registered staff update the plan of care and should revise and update the plan of care whenever there is a change in the resident's status, condition or care needs. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #011's plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During family interviews conducted during stage one of the RQI, resident #001 and resident #011's family members told the Inspectors that staff would often work with two PSWs fewer than scheduled, due to sick calls. They stated the home was unable to replace these staff members.

On March 14, 2016, a family member of a resident approached Inspector #544 and stated that the resident had been in the home for two years and the home was often

short staffed. The resident often waited a long time for assistance when they rang the call bell.

During a resident interview, resident #007 told the Inspector that they would often wait long periods of time for their call bell to be answered by the staff.

Resident #020 told the Inspector that the home often worked short staffed especially when two PSW's would call in sick.

Resident #013 told the Inspector, in an interview, that there were not enough staff in the home in order to get their care needs met. They would call for assistance and their call bell would not be answered in a timely fashion which would result in their continence care needs not being met.

On March 14, 2016, Inspector #612 interviewed PSW #118 who worked in a specific unit. PSW #118 confirmed that they were often short staffed and that the resident baths were occasionally missed. PSW #118 stated that shaving of residents was also not completed when they were short staffed.

PSW #118 stated that on two specific dates in March 2016, resident #012's bath was not completed. They told the Inspector that when they were short staffed and a bath was not completed they charted "No" in Point of Care (POC). The Inspector reviewed the resident's documentation and noted that in POC the resident's baths were charted as not being completed on the two specific dates in March 2016.

Inspector #544 interviewed PSW #120 on March 14, 2016, who worked in the specific unit. They told the Inspector that the home unit often worked short staffed. They stated when this occurred, shaving of male residents and occasionally some resident baths were re-scheduled when possible, but typically the bath was just skipped.

Inspector #544 interviewed PSW #121 who told the Inspector that the staff worked short on almost a daily basis in the specific unit. This meant that the staff worked with one less PSW on the unit. They also stated resident nail care, and shaving of the male residents was often not completed especially when they were two PSWs short.

Inspector #544 interviewed PSW #122 who told the Inspector that the specific unit was, "short staffed quite a bit." PSW #122 stated that the unit was at least one PSW short every two to three days. When this occurred, staff did not take their breaks, male

residents were not shaved, and beds were not made.

Inspector #544 interviewed PSW #123 and PSW #124 who both worked in another specific unit. They both told the Inspector that they tried not to miss resident baths, shaving of the male residents, and providing nail care to the residents but at times this occurred due to a shortage of staff. They stated the unit was often short staffed, "one to two PSWs approximately twice a week".

Inspector #612 reviewed the home's policy, "Staffing Plan", dated May 15, 2015. It stated that on day shift, each unit should have four PSWs. On evening shift, three of the four units had four PSWs, and the fourth unit had three. On night shift, each unit had a PSW and two PSWs were to float throughout the building.

Inspector #612 reviewed the home's policy, "Process for Staff Replacement", dated October 20, 2015. The policy stated that attempts should be made to replace all sick calls on straight time and overtime should not be implemented on days until existing PSWs in the building were redeployed to ensure a particular unit had a minimum of four PSWs, each of the other units had a minimum of three PSWs. The same applied in the evening, a particular should have had four PSWs, and the other units, three PSW's.

Inspector #544 interviewed staff scheduler #117 who provided the Inspector with a list of available shifts for PSW staff, for January, February, and March 2016. The staff scheduler confirmed that the lists of available shifts provided, were shifts that were unfilled and the home did not have a full complement of staff. The staff scheduler indicated that if a PSW was pulled from another unit to ensure that a particular unit was fully staffed, it was not captured or documented anywhere.

Through a review of the documents provided by the staff scheduler it was identified that there were 46 PSW shifts unfilled in January, 38 PSW shifts in February, and 28 PSW shifts between March 1, and 14, 2016. These unfilled shifts included days, evenings and nights.

Inspector #612 interviewed the DOC who stated that when the schedule was posted, all shifts were filled. The reason for unfilled shifts was due to last minute call-ins related to sick calls or staff being on modified duties. The DOC stated that the particular unit should have always been fully staffed; the RN would re-assign staff so that it was fully staffed. The expectation of the home was that all resident care would still be completed. Baths, shaving or nail care would be completed on the next shift or the next day if staff were

unable to complete the care during their shift. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage one of the RQI, Inspector #612 and Inspector #620 observed 35 of the 40 resident's, or 88 per cent of resident's sampled to have had bed rails in the guard position. Specifically resident #003, #005 and #011 were observed while in their bed, with the upper quarter bed rails engaged in the guard position.

Inspector #612 reviewed the Bed Entrapment Testing Report by the Environmental Services Manager (ESM). All beds in the home had been tested for the seven zones of entrapment in 2015, based on the Health Canada Bed Safety Guidelines "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching reliability and other Hazards" guidance document, regardless of bed rail use. The ESM confirmed that they did not assess the resident's for bed rail use.

Inspector #620 reviewed the home's Policy titled, "Bed side Rails-Use Of." The policy stated that, "bed rails may be used by residents to facilitate their independent mobilization in bed and/or transfer in and out of bed." The policy also stated that, "Each resident must be assessed on an individual basis for the use of bed rails and have clear documentation about the need and effectiveness of the bed rail." The policy further noted that, "the use of one bed side rail as a comfort measure or positioning aid, or the use of two bedrails at the request of a resident is not considered a restraint but these preferences must be documented clearly in the care plan."

Inspector #620 interviewed the DOC who stated that the home had not instituted an assessment process to ensure that residents who used bed rails were evaluated for risk; therefore, residents #003, 005 and #011 had not received any assessment related to the bed rails that were currently in use. The DOC stated that an individualized assessment process should have been in place and this had not occurred. [s. 15. (1) (a)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Nutrition and Hydration program's policies and procedures were implemented, specifically the policy titled, "Monitoring Weight and Height".

During stage one of the RQI, Inspector #612 and #620 noted that 33 of 40 residents, or 83 per cent of the residents sampled had their most recent heights documented between 2011 and 2014.

Inspector #620 interviewed RPN #105 who stated that heights were obtained on admission only. The Inspector interviewed the RD who stated that in the home the heights were completed on admission only, however the expectation was that they be completed annually thereafter.

The Inspector reviewed the home's policy in the Food and Nutrition Services Manual

titled, "Monitoring Weight and Height". The policy stated that each resident's height was taken on admission and annually thereafter.

The DOC confirmed that heights should be completed on admission and annually thereafter. [s. 68. (2) (a)]

2. The licensee has failed to ensure that the Nutrition and Hydration program included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration, in consultation with a Registered Dietitian who was a member of the staff of the home.

During stage one of the RQI, Inspector #620 identified through a staff interview that resident #006 had a low Body Mass Index (BMI) and had no planned intervention.

A review of resident #006’s clinical record revealed that the resident had experienced a significant weight change over one month. The clinical record did not contain any documentation that indicated that an assessment of resident #006 had occurred following the home’s documentation of the significant weight change.

Inspector #620 reviewed the home's policy titled, "Weights and Height's Monitoring," last reviewed July 31, 2015. The stated objective of the policy was to ensure that appropriate action/interventions were planned and occurred in a timely manner whenever a resident experienced a significant unplanned weight change or any other weight change that compromised the residents' health status.

Inspector #620 interviewed the RD who stated that they had not been involved in the implementation or development of the home's program for nutrition care and hydration, and should have been.

Inspector #620 interviewed the Food Service Manager (FSM) on March 17, 2016, who stated that they were responsible for the implementation and development of the home's Food and Nutrition Program. They stated that they reviewed the program in consultation with the FSM from an affiliated long term care facility. The FSM confirmed that they were not a RD, nor was the FSM from the affiliated long term care facility. They confirmed that no RD was consulted in the implementation or the development of the home's Food and Nutrition Program, and should have been. [s. 68. (2) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's height is recorded upon admission and annually thereafter as per the home's policy titled, "Monitoring Weight and Height", to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On March 15, 2016, Inspector #612 observed that the medication cart was unlocked in the hallway on a specific unit. The Inspector was unable to find the RPN and stood in the hallway, observing the cart for approximately five minutes. The Inspector observed a resident walk past the medication cart during this time. RPN #134 then emerged from a resident's room. The RPN was not able to see the medication cart from the resident's room.

The Inspector then proceeded to another unit. The Inspector observed the medication cart unlocked in the hallway. The Inspector saw that RPN #133 was in a resident's room with their back to the medication cart. The medication cart was not in their line of sight.

The Inspector interviewed RPN #105 and RPN #119 who confirmed that the medication cart should have been locked when out of RPN's line of sight.

The Inspector reviewed the home's policy #3-5 titled, "The Medication Cart and Maintenance", which stated that to keep the medication cart locked at all times except while in sight of a nurse during a medication pass.

The Inspector interviewed the DOC and ADOC who confirmed that the medication cart should be locked when out of the nurses' line of sight. [s. 129. (1) (a)]

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

On March 15, 2016, Inspector #612 observed that the medication cart was unlocked in the medication room on two specific units. On March 16, 2016, the Inspector observed the medication cart unlocked in the medication room on another specific unit. The RPN's were not in the medication room during these observations.

The Inspector interviewed RPN #105 who confirmed that the medication cart should be locked when not in use in the medication room as they contained controlled medications.

The Inspector interviewed the DOC and ADOC who confirmed that the medication cart should be locked when stored in the medication room as it contained controlled medications. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During stage one of the RQI, Inspector #620 interviewed resident #005's family member who reported a concern related to the residents personal items.

A review of the progress notes for resident #005 revealed that six days after the resident was admitted to the home, their family member called the home and asked RN #107 to have the RPN label the resident's personal items.

Two months later RPN #113 documented in a progress note that resident #005's, personal item was found unmarked. The RPN attempted to locate a labelling kit in the facility but was unsuccessful. RPN #113 noted that the ADOC was made aware.

One month later, RPN #110 documented in a progress note that resident #005 personal item was switched with another resident's personal item. RPN #110 noted that they labelled resident #005's personal item at this time to "avoid further confusion."

A review of the home's Admission Process Policy stated that the RN/RPN were to, "ensure clothing was sent to laundry for labelling and personal articles, such as dentures, toiletries, etc were also labelled."

Inspector #620 interviewed the DOC on March 14, 2016. The DOC confirmed that it was the home's expectation that residents' personal items were labelled on the first day of admission. The DOC stated that resident #005's personal item had not been labelled until 13 weeks following resident #005's admission. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents of the home have their personal items labelled within 48 hours of admission, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with a change of 5 per cent of body weight, or more, over one month were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated.

During stage one of the RQI, Inspector #620 identified through a staff interview that resident #006 had a low Body Mass Index (BMI) and had no planned intervention.

A review of resident #006's clinical record revealed that over one month the resident experienced a weight change greater than five per cent.

The clinical record did not contain any documentation that indicated that an assessment of resident #006 had occurred following the homes documentation of the significant weight change.

Inspector #620 reviewed the home's policy titled, "Weights and Height's Monitoring." The stated objective of the policy was to ensure that, appropriate action/interventions were planned and occurred in a timely manner whenever a resident experienced a significant unplanned weight change, or any other weight change that compromised the resident's health status.

The policy stated that residents’ weights were to be done on admission and monthly thereafter, on the first bath day of each month, as determined by the home's bath schedule, and no later than the seventh day of each month, or more frequently as requested by interdisciplinary staff.

The policy stated that the RD was to address all significant weight changes each month. Nursing staff were directed by the policy to re-weigh residents if the weight was two kilograms over or under the previous month’s weight. The policy also stated that dietary and nursing staff would meet by the 15th day of each month to discuss significant weight changes. Furthermore, the policy advised nursing staff to re-weigh every resident with a questionable weight to verify the accuracy of the weight, and confirm the weight as per the established procedure for the home.

On March 14, 2016, Inspector #620 interviewed the ADOC who stated that significant weight changes should be identified by the RD.

On March 14, 2016, Inspector #620 interviewed RPN #110 who stated that they were unaware that resident #006 had experienced a significant weight change over one month. RPN #110 stated that they do not monitor for significant weight changes experienced by residents because it was a task that was to be conducted by the RD. RPN #110 also stated that PSW staff were responsible for obtaining and documenting residents’ weights; furthermore, if the newly obtained weight represented a significant change the PSW staff would not see the warning in Point of Care because the warning was only visible in Point Click Care, software which was not accessed by PSW staff.

Inspector #620 re-interviewed RPN #110 on March 15, 2016. RPN #110 stated that resident #006 had not been re-weighed following becoming aware of the resident’s significant weight change.

Inspector #620 interviewed the RD on March 15, 2016, whom stated that they were unaware that resident #006 had experienced a significant weight change over one month; therefore, no assessment had occurred as a result of the weight change. The RD

stated that they had not conducted an interdisciplinary meeting with Nursing to review significant weight changes on the fifteenth day of the month as required by the home's Monitoring of Weights and Heights Policy. The RD stated that the resident should have been assessed following the significant weight change, and that this had not occurred, and should have. [s. 69. 1.]

2. The licensee has failed to ensure that residents with a change of 7.5 per cent of body weight, or more, over three months were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

During stage one of the RQI Inspector #612 identified through a staff interview that resident #009 had a low Body Mass Index (BMI) and had no planned intervention.

Inspector #612 reviewed resident #009's clinical record which stated that on a specific date, the resident triggered for a 7.7 per cent weight change over the previous three months. The Inspector noted that the RD completed an assessment related to the resident's significant weight change; however, one month later the RD crossed out the resident's weight on the specific day in the clinical record, indicating "incorrect documentation".

Inspector #620 reviewed the home's policy titled, "Weights and Height's Monitoring." The stated objective of the policy was to ensure that, appropriate action/interventions were planned and occurred in a timely manner whenever a resident experienced a significant unplanned weight change, or any other weight change that compromised the resident's health status.

The policy stated that residents' weights were to be done on admission and monthly thereafter, on the first bath day of each month, as determined by the home's bath schedule, and no later than the seventh day of each month, or more frequently as requested by interdisciplinary staff.

The policy stated that the RD was to address all significant weight changes each month. Nursing staff were directed by the policy to re-weigh residents if the weight was two kilograms over or under the previous month's weight. The policy also stated that Dietary and Nursing staff would meet by the 15th day of each month to discuss significant weight changes. Furthermore, the policy advised nursing staff to re-weigh every resident with a questionable weight to verify the accuracy of the weight, and confirm the weight as per established procedure for the home.

On March 14, 2016, Inspector #620 interviewed the ADOC whom stated that significant weight changes should be identified by the RD.

Inspector #612 interviewed the RD who stated that they had crossed out the documented weight as they suspected that the weight was incorrect. When they found a weight to be incorrect they would get in touch with the registered staff to request the staff re-weigh the resident however, indicated that the re-weigh had not occurred. The RD confirmed there was no further documentation to indicate why the weight for the specific date was struck out. The RD confirmed that the assessment of a significant weight change was not completed in a timely manner.

During an interview between Inspector #620 and the RD, the RD confirmed that they do not conduct interdisciplinary meetings with nursing to review significant weight changes on the fifteenth day of the month as required by the home's Monitoring of Weights and Heights Policy. [s. 69. 2.]

3. The licensee has failed to ensure that residents with a change of 7.5 per cent of body weight, or more, over three months were assessed using an interdisciplinary approach, and that actions were taken and outcomes were evaluated:

During stage one of the RQI Inspector #620 identified through record review that resident #023 experienced a significant weight change.

A review of resident #023's clinical record revealed that the resident had triggered for a weight change greater than 7.5 per cent over three months. The clinical record did not contain any documentation that indicated that an assessment of resident #023's weight change had occurred following the homes documentation of the significant weight change.

Inspector #620 reviewed the home's policy titled, "Weights and Height's Monitoring." The stated objective of the policy was to ensure that, appropriate action/interventions were planned and occurred in a timely manner whenever a resident experienced a significant unplanned weight change, or any other weight change that compromised the resident's health status.

The policy stated that residents' weights were to be done on admission and monthly thereafter, on the first bath day of each month, as determined by the home's bath

schedule, and no later than the seventh day of each month, or more frequently as requested by interdisciplinary staff.

The policy stated that the RD was to address all significant weight changes each month. Nursing staff were directed by the policy to re-weigh residents if the weight was two kilograms over or under the previous month's weight. The policy also stated that dietary and nursing staff would meet by the 15th day of each month to discuss significant weight changes. Furthermore, the policy advised nursing staff to re-weigh every resident with a questionable weight to verify the accuracy of the weight, and confirm the weight as per established procedure for the home.

On March 14, 2016, Inspector #620 interviewed the ADOC whom stated that significant weight changes should be identified by the RD.

On March 15, 2016, Inspector #620 interviewed RPN #125 who stated that they were unaware that resident #023 had experienced a significant weight change on a specific date. RPN #123 stated that they were unaware of any requirement to monitor for significant weight changes experienced by residents. RPN #125 was unaware of the requirement to re-weigh a resident following the documentation of a significant weight change.

On March 14, 2016, Inspector #620 interviewed RPN #110 who stated that PSW staff were responsible for obtaining and documenting residents' weights; furthermore, if the newly obtained weight represented a significant change the PSW staff would not see the warning in Point of Care (POC) because the warning was only visible in Point Click Care (PCC), which PSW staff typically did not access.

Inspector #620 interviewed the RD on March 17, 2016, whom stated that they were unaware that resident #023 had experienced a significant weight change on a specific date; therefore, no assessment had occurred as a result of the weight change. The RD stated that they had not conducted an interdisciplinary meeting with nursing to review significant weight changes on the fifteenth day of the month as required by the home's Monitoring of Weights and Heights Policy. The RD stated that the resident should have been assessed following the significant weight change, and that this had not occurred, and should have. [s. 69. 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all residents with weight changes of 5 per cent or more over one month, 7.5 per cent over three months or 10 per cent over six months, are assessed using an interdisciplinary approach, and that actions are taken and outcomes evaluated, to be implemented voluntarily.

WN #8: 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 all staff received annual retraining related to the following: The Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse, and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections.

During an interview with RN #106 on March 16, 2016, they stated to Inspector #612 that they had not received any retraining related to the home's policy to promote zero tolerance of abuse and neglect of residents, duty to make mandatory reports under section 24 and whistle-blowing protections in the last year.

The DOC confirmed with Inspector #612 during an interview that the retraining was offered to staff annually via online modules, and in-person education sessions. The DOC provided the Inspector with the 2015 retraining records for Elder Abuse, Mandatory reporting and Whistle Blowing which 11% of staff had not completed. The retraining records for Residents' Rights indicated that 33% of staff had not completed the retraining in 2015.

The Inspector interviewed the ADOC who confirmed that the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and whistle-blowing protections was mandatory annual retraining and confirmed that it was not completed by all staff in 2015. [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 to ensure that all staff receive retraining annually related to The Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 and whistle-blowing protections, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

On March 15, 2016, Inspector #612 observed the medication pass on a specific unit. The Inspector observed RPN #119 administer medications to three residents and place the empty pouches in the garbage at the end of the medication cart. The Inspector observed that the pouches contained the resident's name as well as the medications that were in the pouch.

The Inspector interviewed RPN #119 who stated that the garbage at the end of the medication cart goes out with the regular garbage in the home. They stated that the expectation was that the pouches were soaked in water so that the resident's name and medications would come off; however, the ink would not come off of the "new" pouches.

The Inspector reviewed the home's policy #3-6, The Medication Pass, dated January 1, 2014, which stated that empty strip pouches could be destroyed with water to remove information and then placed into the garbage or shredded.

During an interview with the ADOC on March 17, 2016, they confirmed that the expectation was for staff to soak the packages so the resident information was removed prior to placing them into the garbage. [s. 3. (1) 11. iv.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

During stage one of the RQI, resident #002 was identified through Minimum Data Set (MDS) data to have had a significant change in their continence.

Inspector #620 reviewed resident #002's clinical record which indicated that on a specific date, an annual MDS assessment warned of a significant change to continence for resident #002.

Further review of the clinical record revealed no indication that an assessment which included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, had been conducted.

Inspector #620 reviewed the home's "Continence Care Program" policy, last reviewed September, 2015. The policy stated that a continence assessment was to be completed using the, "Bowel and Bladder Continence Assessment" on admission, and with any change that may affect continence. The policy also stated that bowel and bladder continence assessment should have been conducted by the RN/RPN following any change in condition.

Inspector #620 interviewed RPN #110 who sated that no continence assessment had been conducted for resident #002 following their MDS significant change warning.

Inspector #620 interviewed the ADOC who stated that it was the home's expectation that all significant changes to residents' continence were to be assessed using the Bowel and Bladder Continence Assessment Tool. The ADOC confirmed that resident #002 had experienced a significant change to their continence. They stated that as a result of this change, a continence assessment should have been conducted, and that this had not occurred, and should have. [s. 51. (2) (a)]

WN #11: 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).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

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

On March 15, 2016, Inspector #612 observed RPN #119 administer medications to three residents. The Inspector observed that the RPN did not perform hand hygiene between the residents. RPN #119 then stated that they should be performing hand hygiene between administering the medications to the three resident's however they did not have a hand sanitizer bottle on their medication cart to utilize.

The Inspector interviewed RPN #105 and RN #106 who stated that hand hygiene should be performed before and after resident contact.

The Inspector reviewed the home's policy titled, "Hand Hygiene," last reviewed November 4, 2015. The policy stated that there were four key moments in the provision of care where hand hygiene was imperative which included before and after initial patient contact and before and after patient environment contact.

The Inspector interviewed the ADOC and the DOC who confirmed that hand hygiene should be performed before and after resident contact. The ADOC confirmed that during a medication pass, the registered staff should perform hand hygiene between each resident. [s. 229. (4)]

2. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored in accordance with evidence-based practices and, if there are none, inaccordinance with prevailing practices.

During stage one of the RQI, resident #010 was identified through MDS data to have had a previous specific infection.

The Inspector reviewed resident #010's progress notes and identified that resident #010 had exhibited signs and symptoms of a specific infection on a specific date, and that the resident was to be placed on isolation precautions. There were no progress notes or monitoring documented every shift related to resident #010's signs and symptoms of the specific infection. There was also no documentation that identified when resident #010's specific symptoms subsided.

A review of the home's monthly infection audit identified that resident #010 was not placed on isolation. There was no documentation to support that resident #010 was placed on a specific isolation. Therefore, the Personal Protective Equipment (PPE), was not outside the resident's room for staff and visitor use.

During an interview, the ADOC confirmed that resident #010 should have been identified as being on a specific isolation, and resident #010 was not. The ADOC also confirmed that the progress notes should have been written on every shift during the course of resident #010's specific infection and there was no documentation to support when resident #010's signs and symptoms of the specific infection subsided and there should have been. [s. 229. (5) (a)]

Issued on this 2nd day of June, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH CHARETTE (612), ALAIN PLANTE (620), FRANCA MCMILLAN (544)
Inspection No. / No de l'inspection :	2016_320612_0007
Log No. / Registre no:	005679-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 31, 2016
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH CENTRE OF SUDBURY 1140 South Bay Road, SUDBURY, ON, P3E-0B6
LTC Home / Foyer de SLD :	ST.GABRIEL'S VILLA OF SUDBURY 4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Ray Ingriselli

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)

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 develop and implement the following:

1. A process to ensure that for residents #003, #011, and all other residents in the home, the care set out in the plan of care is provided as specified in the plan.

2. Develop and implement an auditing process that will identify when staff are not providing care as specified in the plan of care so that corrective actions can be taken.

3. A multidisciplinary process which ensures clear communication between the Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Registered Dietitian (RD) and other members of the interdisciplinary team related to the requirements in the resident's plans of care.

Grounds / Motifs :

1. During stage one of the RQI, Inspector #612 interviewed resident #011's family member. They identified they were concerned resident #011 was not receiving the assistance they required.

Inspector #612 observed resident #011 during a meal service on March 10, 2016, and another meal on March 14, 2016. The Inspector observed that the resident was provided a specific food at both meals. The Inspector also observed that at the end of the meal service on March 10, 2016, all staff left the dining room. The resident was left alone in the dining room, eating their specific food for fifteen minutes. The Inspector noted the consistency of the food.

The Inspector reviewed the resident's most recent care plan and the following was listed:
- Ensure that the specific food provided to the resident was a specific consistency.
- Monitor closely during meals for signs identified in the care plan.

The Inspector interviewed the RD, who stated that they see the resident frequently along with another member of the multidisciplinary team. The resident had extensive interventions listed in their plan of care. The RD confirmed that staff were to ensure that the consistency of the specific food was appropriate as identified in the care plan. They also stated that the resident was to be closely monitored for the entire meal as indicated in their care plan.

The Inspector interviewed PSW #109, RPN #105 and RN #106 who confirmed that registered staff should have supervised the resident throughout the entire meal. RPN #105 stated that they had not made any adjustments to the resident's specific food and just served the food as it was prepared by the kitchen staff.

The Inspector interviewed the DOC who confirmed that the care was not provided to the resident as specified in the plan of care, and should have been. (612)

2. During an interview with resident #003, they reported to Inspector #612 that the evening staff were rude to them while they provided care on a specific date. The resident was unable to provide the staff member's name.

A review of the home's investigation indicated that PSW #128 had responded to resident #003's call bell to provide assistance to the resident and that they had assisted the resident.

Inspector #612 reviewed the resident's care plan, which provided specific instructions to staff on how to provide care to the resident.

The Inspector interviewed PSW #128 who confirmed they had provided care to the resident on the specific date. They stated that they were unaware of the specific instructions provided in the residents care plan and confirmed they had not provided care as per the care plan.

The Inspector interviewed PSW #118 and RN #106 who confirmed that there were specific instructions in the plan of care in regards to the care resident #003 requires.

The Inspector interviewed the DOC who confirmed that it was the home's expectation that staff provided care to residents as indicated in their plan of care.

The decision to issue this compliance order was based on the scope, which was isolated and the severity, which was a potential for risk/harm to the residents. The home's compliance history included a voluntary plan of correction (VPC) issued during Follow Up Inspection #2015_282543_0023, a written notification (WN) issued during the 2015 Resident Quality Inspection (RQI) #2015_380593_0015, a compliance order (CO) issued during Follow Up Inspection #2013_211106_0020 and the 2013 RQI #2013_099188_0015. A VPC was also issued during a Critical Incident Inspection #2013_140158_0007. The grounds from the Follow Up Inspection #2013_211106_0020 and the 2013 RQI specifically related to residents not being monitored while they were eating, as indicated in the plan of care. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,

(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and

(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee shall prepare, submit, and implement a plan to ensure that the organized program of personal support services for the home will meet the assessed needs of the residents.

The plan shall include the following:

1. How the licensee will ensure that there is an adequate number of Personal Support Workers (PSWs) to meet the needs of all the residents in the home, on all shifts, and on every unit.

2. The steps the licensee will take to ensure that all residents receive their preferred scheduled baths, and that personal care is completed as indicated in their plan of care.

3. An auditing process to track and ensure that the residents receive the care they require as set out in their plan of care.

4. Who will be responsible to review and assess the staffing complement going forward, for all shifts, and all units, and how often this will be completed to ensure the needs of the residents are met.

The plan must be faxed, to the attention of LTCHI Sarah Charette, at (705) 564-3133. The plan is due on June 14, 2016, with a compliance date of July 15, 2016.

Grounds / Motifs :

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

During family interviews conducted during stage one of the RQI, resident #001 and resident #011's family members told the Inspectors that staff would often work with two PSWs fewer than scheduled, due to sick calls. They stated the home was unable to replace these staff members.

On March 14, 2016, a family member of a resident approached Inspector #544 and stated that the resident had been in the home for two years and the home was often short staffed. The resident often waited a long time for assistance when they rang the call bell.

During a resident interview, resident #007 told the Inspector that they would often wait long periods of time for their call bell to be answered by the staff.

Resident #020 told the Inspector that the home often worked short staffed especially when two PSW's would call in sick.

Resident #013 told the Inspector, in an interview, that there were not enough staff in the home in order to get their care needs met. They would call for assistance and their call bell would not be answered in a timely fashion which would result in their continence care needs not being met.

On March 14, 2016, Inspector #612 interviewed PSW #118 who worked in a specific unit. PSW #118 confirmed that they were often short staffed and that the resident baths were occasionally missed. PSW #118 stated that shaving of residents was also not completed when they were short staffed.

PSW #118 stated that on two specific dates in March 2016, resident #012's bath was not completed. They told the Inspector that when they were short staffed and a bath was not completed they charted "No" in Point of Care (POC). The Inspector reviewed the resident's documentation and noted that in POC the resident's baths were charted as not being completed on the two specific dates in March 2016.

Inspector #544 interviewed PSW #120 on March 14, 2016, who worked in the specific unit. They told the Inspector that the home unit often worked short staffed. They stated when this occurred, shaving of male residents and occasionally some resident baths were re-scheduled when possible, but typically the bath was just skipped.

Inspector #544 interviewed PSW #121 who told the Inspector that the staff worked short on almost a daily basis in the specific unit. This meant that the staff worked with one less PSW on the unit. They also stated resident nail care, and shaving of the male residents was often not completed especially when they were two PSWs short.

Inspector #544 interviewed PSW #122 who told the Inspector that the specific unit was, "short staffed quite a bit." PSW #122 stated that the unit was at least one PSW short every two to three days. When this occurred, staff did not take

their breaks, male residents were not shaved, and beds were not made.

Inspector #544 interviewed PSW #123 and PSW #124 who both worked in another specific unit. They both told the Inspector that they tried not to miss resident baths, shaving of the male residents, and providing nail care to the residents but at times this occurred due to a shortage of staff. They stated the unit was often short staffed, "one to two PSWs approximately twice a week".

Inspector #612 reviewed the home's policy, "Staffing Plan", dated May 15, 2015. It stated that on day shift, each unit should have four PSWs. On evening shift, three of the four units had four PSWs, and the fourth unit had three. On night shift, each unit had a PSW and two PSWs were to float throughout the building.

Inspector #612 reviewed the home's policy, "Process for Staff Replacement", dated October 20, 2015. The policy stated that attempts should be made to replace all sick calls on straight time and overtime should not be implemented on days until existing PSWs in the building were redeployed to ensure a particular unit had a minimum of four PSWs, each of the other units had a minimum of three PSWs. The same applied in the evening, a particular should have had four PSWs, and the other units, three PSW's.

Inspector #544 interviewed staff scheduler #117 who provided the Inspector with a list of available shifts for PSW staff, for January, February, and March 2016. The staff scheduler confirmed that the lists of available shifts provided, were shifts that were unfilled and the home did not have a full complement of staff. The staff scheduler indicated that if a PSW was pulled from another unit to ensure that a particular unit was fully staffed, it was not captured or documented anywhere.

Through a review of the documents provided by the staff scheduler it was identified that there were 46 PSW shifts unfilled in January, 38 PSW shifts in February, and 28 PSW shifts between March 1, and 14, 2016. These unfilled shifts included days, evenings and nights.

Inspector #612 interviewed the DOC who stated that when the schedule was posted, all shifts were filled. The reason for unfilled shifts was due to last minute call-ins related to sick calls or staff being on modified duties. The DOC stated that the particular unit should have always been fully staffed; the RN would re-assign staff so that it was fully staffed. The expectation of the home was that all

resident care would still be completed. Baths, shaving or nail care would be completed on the next shift or the next day if staff were unable to complete the care during their shift.

The decision to issue this compliance order was based on the scope, which was identified as a pattern, the severity, which was identified as potential for actual harm and the compliance history which indicated a history of unrelated non-compliances. (544)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2016

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1. Develop and implement a process to ensure that a full bed rail risk assessment is completed for all residents with bed rails in accordance with the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" and utilize the following document to assist in the development of the bed rail assessment: Clinical Guidance For the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings developed by the Hospital Bed Safety Workgroup.

2. Maintain a record for each resident where bed rails are used, which includes when the resident was assessed and the results of the assessment.

3. Ensure that where bed rails are used, the resident's plan of care provides clear directions to all staff related to bed rail use.

4. Train all staff who provide direct care to residents related to assessment, use and risks associated with bed rail use.

5. Maintain a document of the required training, when it was completed, what staff completed the training and what the training entailed.

Grounds / Motifs :

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

During stage one of the RQI, Inspector #612 and Inspector #620 observed 35 of the 40 resident's, or 88 per cent of resident's sampled to have had bed rails in the guard position. Specifically resident #003, #005 and #011 were observed while in their bed, with the upper quarter bed rails engaged in the guard position.

Inspector #612 reviewed the Bed Entrapment Testing Report by the Environmental Services Manager (ESM). All beds in the home had been tested for the seven zones of entrapment in 2015, based on the Health Canada Bed Safety Guidelines "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail

Latching reliability and other Hazards" guidance document, regardless of bed rail use. The ESM confirmed that they did not assess the resident's for bed rail use.

Inspector #620 reviewed the home's Policy titled, "Bed side Rails-Use Of." The policy stated that, "bed rails may be used by residents to facilitate their independent mobilization in bed and/or transfer in and out of bed." The policy also stated that, "Each resident must be assessed on an individual basis for the use of bed rails and have clear documentation about the need and effectiveness of the bed rail." The policy further noted that, "the use of one bed side rail as a comfort measure or positioning aid, or the use of two bedrails at the request of a resident is not considered a restraint but these preferences must be documented clearly in the care plan."

Inspector #620 interviewed the DOC who stated that the home had not instituted an assessment process to ensure that residents who used bed rails were evaluated for risk; therefore, residents #003, 005 and #011 had not received any assessment related to the bed rails that were currently in use. The DOC stated that an individualized assessment process should have been in place and this had not occurred.

The decision to issue this CO was based on the scope, which was widespread, the severity which was a potential for actual harm, and the compliance history which included a VPC issued during the 2015 RQI, inspection #2015_380593_0015. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2016

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,

(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration;

(b) the identification of any risks related to nutrition care and dietary services and hydration;

(c) the implementation of interventions to mitigate and manage those risks;

(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and

(e) a weight monitoring system to measure and record with respect to each resident,

(i) weight on admission and monthly thereafter, and

(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Order / Ordre :

The licensee shall ensure that:

1. The Registered Dietitian, who is a member of the staff of the home, reviews and evaluates the home's Nutrition and Hydration program.

2. A record is kept of the review, which includes who participated in the review, any changes or recommendation made as a result of the evaluation and the date the changes were implemented.

3. Training is provided to direct care staff, including Personal Support Workers (PSWs) and Registered staff (RNs and RPNs) in regards to the outcome of the review of the Nutrition and Hydration program and any changes made.

4. Maintain a record of the training including what the training entailed, who completed it and when it was completed.

Grounds / Motifs :

1. The licensee has failed to ensure that the Nutrition and Hydration program included the development and implementation of policies and procedures related to nutrition care and dietary services and hydration, in consultation with a Registered Dietitian who was a member of the staff of the home.

During stage one of the RQI, Inspector #620 identified through a staff interview that resident #006 had a low Body Mass Index (BMI) and had no planned intervention.

A review of resident #006's clinical record revealed that the resident had experienced a significant weight change over one month. The clinical record did not contain any documentation that indicated that an assessment of resident #006 had occurred following the home's documentation of the significant weight change.

Inspector #620 reviewed the home's policy titled, "Weights and Height's Monitoring," last reviewed July 31, 2015. The stated objective of the policy was to ensure that appropriate action/interventions were planned and occurred in a timely manner whenever a resident experienced a significant unplanned weight change or any other weight change that compromised the residents' health status.

Inspector #620 interviewed the RD who stated that they had not been involved in the implementation or development of the home's program for nutrition care and hydration, and should have been.

Inspector #620 interviewed the Food Service Manager (FSM) on March 17, 2016, who stated that they were responsible for the implementation and development of the home's Food and Nutrition Program. They stated that they reviewed the program in consultation with the FSM from an affiliated long term care facility. The FSM confirmed that they were not a RD, nor was the FSM from the affiliated long term care facility. They confirmed that no RD was consulted in the implementation or the development of the home's Food and Nutrition Program, and should have been.

The decision to issue this CO was based on the scope, which was identified as widespread, the severity, which was a potential for actual harm to the residents and the compliance history which included a WN which was previously issued during RQI inspection #2014_332575_0014. (620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 12, 2016

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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
(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).

Order / Ordre :

The licensee shall ensure that:

1. All medication carts are kept secure and locked;

2. Controlled substances are stored in a separate locked area within the locked medication cart;

3. Training and education is provided to registered nursing staff to ensure compliance with O. Reg. 79/10, s. 129 (1) (a) and (b) and;

4. A record is kept of the training which includes who completed the training, the date it was completed and what the training entailed.

Grounds / Motifs :

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

On March 15, 2016, Inspector #612 observed that the medication cart was unlocked in the hallway on a specific unit. The Inspector was unable to find the RPN and stood in the hallway, observing the cart for approximately five minutes. The Inspector observed a resident walk past the medication cart during this time. RPN #134 then emerged from a resident's room. The RPN was not able to see the medication cart from the resident's room.

The Inspector then proceeded to another unit. The Inspector observed the medication cart unlocked in the hallway. The Inspector saw that RPN #133 was in a resident's room with their back to the medication cart. The medication cart was not in their line of sight.

The Inspector interviewed RPN #105 and RPN #119 who confirmed that the medication cart should have been locked when out of RPN's line of sight.

The Inspector reviewed the home's policy #3-5 titled, "The Medication Cart and Maintenance", which stated that to keep the medication cart locked at all times except while in sight of a nurse during a medication pass.

The Inspector interviewed the DOC and ADOC who confirmed that the medication cart should be locked when out of the nurses' line of sight. (612)

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

On March 15, 2016, Inspector #612 observed that the medication cart was unlocked in the medication room on two specific units. On March 16, 2016, the Inspector observed the medication cart unlocked in the medication room on another specific unit. The RPN's were not in the medication room during these observations.

The Inspector interviewed RPN #105 who confirmed that the medication cart should be locked when not in use in the medication room as they contained controlled medications.

The Inspector interviewed the DOC and ADOC who confirmed that the medication cart should be locked when stored in the medication room as it contained controlled medications.

The decision to issue this compliance order was based on the severity, which was minimum risk, the scope, which was widespread and the compliance history which included a VPC issued during the 2015 and 2014 RQIs, inspection #2015_380593_0015 and #2014_332575_0014 and a WN issued during a Critical Incident Inspection, #2013_140158_0007. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 28, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 31st day of May, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Charette

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