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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 25, 2016	2016_282543_0023	012617-16, 014242-16, 016509-16, 017521-16, 020533-16, 021118-16, 021223-16, 021680-16, 022081-16, 022409-16, 022517-16, 023546-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

TIFFANY BOUCHER (543), CHAD CAMPS (609), MISHA BALCIUNAS (637), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 26-29, August 2-5 and August 8-9, 2016

This Critical Incident Inspection is related to 12 critical incidents the home submitted; five related to alleged abuse; two related to elopement; one related to falls; one related to missing medication; one related to responsive behaviours; one related to resident care and one related to an unexpected death.

A Complaint Inspection was conducted concurrently with this inspection. For additional findings of non-compliance please refer to inspection #2016_282543_0024.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, policies, procedures, programs, and staff personnel files.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director(s) of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Dietary Manager, the Support Service Manager, the Educational Co-ordinator and the Office Manager.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

6 WN(s)
3 VPC(s)
2 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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #543 reviewed a critical incident (CI), submitted to the Director in July, 2016, regarding the unexpected death of resident #001.

According to the report, resident #001 was in the dining room, and was choking on their food. The CI report described that the Nurse in Charge was called, and observed that the resident was not responding. Paramedics were called for assistance, CPR had been initiated by staff in the home, and halted by paramedics. The paramedics reassessed the resident, whose vital signs were absent.

A review of the home's "Emergency Procedures: Suctioning of the Airway- CLIN-04-03-03" policy identified that each facility must have at least one suction catheter, collecting bottle, tubing and suction machine easily accessible and in optimum working condition and available at all times for emergency use.

A review of the home's "Emergency Procedures: Suctioning of the Airway- CLIN-04-03-05A" policy identified that suctioning equipment would be stored in a place which was well known and accessible to all staff. The suction equipment would not be stored in a locked area.

During an interview with RPN #102, they stated, that a PSW was looking for a suction

machine in the dining room and there was none (both were in the medication room). When they did get the suction machine it was not functional, and they had to get another one.

During an interview with PSW #104, they stated that on the day of the incident when resident #001 choked in the dining room, they could not locate the suction machine that was normally kept there.

During an interview with PSW #105, they stated that they called out for a suction machine, which was usually in the corner in the dining room, but it was not there that day. They stated that another staff member went to the medication room, and got another suction machine, but that machine was missing pieces of tubing.

During an interview with RPN #106, they stated that the RNs arrived on the floor and called for a suction machine. When the suction machine was given to the RN it had not been equipped with the proper tubing, therefore, they had to wait for another suction machine. This RPN confirmed that each unit was supposed to have one suction machine in the medication room and one in dining room.

During an interview with the DOC, they stated that there should always be a suction machine kept in the medication room and that one should be kept in the dining room. The DOC also verified that the suction machine that they had taken from the medication room did not have the proper tubing.

A review of the home’s "Emergency Procedures: Aid to Choking- CLIN-04-01-03" policy identified that regardless of the status and level of the individual Advance Directives, residents who choke would receive appropriate intervention aimed at relieving the airway obstruction. Registered Nurses and Registered Practical Nurses must successfully demonstrate competence in adult foreign-body airway obstruction, including complete airway obstruction on orientation and annually thereafter. All Care Aides and Recreational and Rehabilitation Aides must successfully demonstrate safe feeding techniques and complete airway obstruction (conscious victim) on orientation and annually thereafter.

On July 27, 2016, the Inspector was approached by the DOC, who stated that the home did not require non registered staff members (PSWs) to be certified in CPR. Some of the PSWs had provided proof of certification when hired, but it was not tracked as it was not a requirement.

On July 27, 2016, the Inspector spoke with the Administrator who confirmed that the home had not provided annual training related to choking and suctioning on an annual basis. They also verified that conversations had been ongoing with the management team related to the gap in training with regards to suctioning of residents.

According to the LTCHA 2007, s. 87 (1) (a), every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including, measures for dealing with emergencies.

2. Inspector #543 reviewed the home's daily Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW) planned schedules for July, 2016. This document identified that several of the floors were working short staffed. Each of the units was short one PSW.

A review of the home's "Staffing Patterns: Staffing- NURS-02-02-01" policy identified that the nursing department was staffed on current budget, resident classification (levels of care), and number of units. This policy also stated that staffing patterns may have to be adapted according to resident needs, and that staffing patterns would be reviewed on a regular basis and at least once per year.

In an interview with PSW #105, they stated that resident #001 had not been supervised at the meal time. They verified that the floor was working in Plan B, short one PSW. They stated that resident #001 was seated in an area in the dining room where nobody could directly see the resident's face. The PSW further stated that staff were working short a PSW, and normally the RPN would have been in resident #001's section but they had been serving other residents. PSW #105 indicated that usually when a floor was short staffed, a PSW from other floors would come to with the meal service; however on that day in particular that had not occurred.

In an interview with PSW #104, they stated it was the meal service and staff were working in Plan B, short a PSW. They indicated that another PSW was getting up to grab a dessert and noted that resident #001 was not well.

In an interview with the DOC Clerk #114, they verified that the staff were working short staffed on that day in July, 2016. They also indicated that other floors were also short staffed that day.

In an interview with the DOC, they verified that on on that day in July, 2016, the dining room was working short staffed. They also verified that the RPN had not been in the dining room as they were pulled from the dining room to receive a medication delivery.

According to O. Reg. 79/10, s. 31, every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2). The staffing plan must, provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation. [s. 8. (1) (b)]

2. A CI report, was submitted to the Director in July, 2016, which reported that a one half tablet of a controlled substance was discovered missing.

Inspector #609 reviewed the home's internal investigation which found that on a day in July, 2016, RPN #134 had completed the afternoon narcotic count alone. RPN #115 was not present during that narcotic count but signed the second signature identifying that the count had been correct. During the evening narcotic count RPN #133 and #134 identified that the narcotic count was missing a one half tablet of a controlled substance and had altered the narcotic count sheet's previous entry with an inaccurate amount of remaining half tablets. The next day, upon discovering that their signed count sheet had been altered, RPN #115 notified the home of the missing narcotic. The narcotic was never recovered.

During observations of the afternoon shift change narcotic count on August 8, 2016, RPN #135 and RPN #136, stated that narcotic counts were always done with two registered staff present and that if they became aware of any missing controlled substance, they would immediately notify the RN supervisor.

A review of the home's policy titled, "Combined Individual Monitored Medication Record with Shift Count- 6-7" last reviewed January 2014, indicated that at shift change, two registered staff (leaving and arriving), together; counted the actual quantity of medications remaining; confirmed the actual quantity was the same as the amount recorded on the last entry; and recorded the date, time and quantity of the medications and sign. The policy also indicated that any discrepancies were to be reported to the DOC (or delegate) immediately.

During an interview with the ADOC on August 9, 2016, they verified that RPNs #134 and #115 had not performed the narcotic count together, that RPNs #134 and #133 had

identified a discrepancy in the narcotic count and had altered the narcotic count sheet and had not reported the discrepancy to the RN supervisor. The ADOC stated that the three RPNs identified had not complied with the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A CI report, that was submitted to the Director in July, 2016, described the unexpected death of resident #001.

According to the CI report, resident #001 was in the dining room, and was choking on their food. The CI report described that the Nurse in Charge was called, and observed that the resident was not responding. Paramedics were called for assistance and CPR had been initiated by staff in the home, and halted by paramedics. The paramedics reassessed the resident, whose vital signs were absent.

During an interview with PSW #104, they stated that the day of the incident they could not locate the suction machine that was normally kept there.

During an interview with PSW #105, they stated that they called out for a suction machine, which was usually stored in the corner of the dining room, but it was not there that day. Another staff member went to medication room, and got another suction machine, but that machine was missing pieces of tubing.

During an interview with RPN #106 they stated that the RNs arrived on the floor and called for a suction machine. When the suction machine was given to the RN it had not been equipped with the proper tubing therefore, they had to wait for another suction machine.

During an interview with the DOC, they stated that there should always be a suction machine kept in the medication room and that one should be kept in the dining room. The DOC also verified that the suction machine that they had taken from the medication room did not have the proper tubing. [s. 44.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any time when the resident's care needs changed.

A CI report, was submitted to the Director in July, 2016, which indicated that in July, 2016 , resident #013 fell which resulted in the resident being taken to the hospital resulting in an injury.

Inspector #609 reviewed resident #013's current plan of care which indicated that the resident required mobility assistance.

During an interview with PSW #123 on August 5, 2016, they stated that since the resident returned to the home there was a change with the resident's continence needs.

A review of a continence product sheet verified there was no mention of the change in resident #013's continence care needs.

During an interview with RN #124 on August 5, 2016, they stated that the plan of care for resident #013 had not been updated with the resident's current continence care needs.

During an interview with the DOC on August 5, 2016, they stated "yes" when asked if it was the expectation of the home that the plan of care for every resident was to be reviewed and revised at any time when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #013's is reassessed and the plan of care is reviewed and revised at any time when the resident's care needs changed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CI report, was submitted to the Director in July, 2016, that described an incident whereby resident #010 struck resident #011, resulting in altered skin integrity.

A record review of resident #011's plan of care with RPN #115 indicated that there had been no "skin alert assessment" initiated for resident #011 after they had altered skin integrity. The "skin alert assessment" is the home's initial assessment whenever a new skin integrity issue arises, which is filled out describing the wound. This assessment is utilized for as a reference tool related to skin integrity issues.

Inspector #638 reviewed the policy titled “Skin and Wound Management”, last revised July 2016, which indicated that there should be a completed skin and wound observation and communication form or electronic equivalent for every new wound a resident sustained.

In an interview with Inspector #638, RPN #115 indicated that they were the responding staff member during the altercation between resident #010 and #011 in July, 2016. In a concurrent interview with RPN #115, they stated that for every incident in which skin integrity had been altered it was the home’s expectation that a skin assessment would be initiated using the skin alert assessment.

In an interview with Inspector #638, the DOC indicated that it was the expectation of the home that for every new wound, a skin alert assessment would have been initiated in order to effectively monitor the wound. [s. 50. (2) (b) (i)]

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 resident #011 who is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were written protocols for the referral of residents to specialized resources.

A CI report, was submitted to the Director, where resident #010 had physically responsive behaviours towards another resident in the home in which an injury had resulted.

A review of the home's behaviour support team (BSO) referral process with RPN #107, who was a member of the BSO team, indicated that when there was a new or escalating behaviour, it was expected that staff complete the BSO referral form.

A review of the policy titled, "Responsive Behaviours – 09-05-01" indicated that there was no written protocol related to the BSO referral form.

In an interview with Inspector #638, RPN #128 stated that when residents have exhibited new or escalating responsive behaviours that were no longer manageable by staff, a BSO referral form would be initiated. In a concurrent interview, RPN #128 indicated that it was not clear if there were written protocols related to the use of the referral form.

Inspector #638 interviewed RN #129, who indicated that the process for the BSO referral form was passed on verbally and they were not aware of any written protocols for the referral form.

A record review with the DOC indicated that there was no written protocol for the "Behaviour Support Team Referral Form" in order to give clear direction to staff and that the process had only been relayed verbally to new staff. In a concurrent interview, the DOC stated that there should have been a written protocol for the referral of residents to specialized resources. [s. 53. (1) 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 there are written protocols for the referral of residents to specialized resources, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity.

A CI report, was submitted to the Director in April, 2016, which described resident #007 feeling humiliated, belittled and disrespected by PSW #108.

Inspector #637 interviewed RPN #102 who stated that they had observed PSW #108 talking in a loud tone and being disrespectful towards resident #007, in the hallway.

Inspector #637 interviewed resident #007 who stated that PSW #108 verbally raised their voice and was rude during an incident that had occurred.

Inspector #637 interviewed the DOC who stated that PSW #108 had been in violation of the Residents' Bill of Rights, by their overall verbal tone and approach used towards resident #007. The DOC verified that it was the home's expectation that all staff comply with the Residents' Bill of Rights. [s. 3. (1) 1.]

Issued on this 26th day of October, 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) :	TIFFANY BOUCHER (543), CHAD CAMPS (609), MISHA BALCIUNAS (637), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2016_282543_0023
Log No. / Registre no:	012617-16, 014242-16, 016509-16, 017521-16, 020533-16, 021118-16, 021223-16, 021680-16, 022081-16, 022409-16, 022517-16, 023546-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 25, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3
	Tracy Lamirande

Name of Administrator /
Nom de l'administratrice
ou de l'administrateur :

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

1) The licensee shall ensure that:

a) the home's "Combined Individual Monitored Medication Record with Shift Count 6-7" policy is complied with, and

b) the home's staff who are involved in the administration or destruction of medications review the above mentioned policy, and

c) the home maintains a record of all staff who were required to review the policy.

2) The licensee shall ensure that:

a) the home's "Emergency Procedures: Suctioning of the Airway", #CLIN-04-03-03, "Emergency Procedures: Suctioning of the Airway", #CLIN-04-03-05A, and their "Emergency Procedures: Aid to Choking", #CLIN-04-01-03 policies are complied with,

b) the home provides training or retraining to all caregiving staff for the above mentioned policies, and

c) the home maintains a record of the required training or retraining, who completed the training or retraining, and dates the training occurred.

3) The licensee shall ensure that:

a) the home's Staffing Patterns: Staffing- NURS-02-02-01 policy are complied with, and

b) staffing patterns are consistent and adapted according to the care needs of the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A CI report, was submitted to the Director in July, 2016, which reported that a one half tablet of a controlled substance was discovered missing.

Inspector #609 reviewed the home's internal investigation which found that on a day in July, 2016, RPN #134 had completed the afternoon narcotic count alone. RPN #115 was not present during that narcotic count but signed the second signature identifying that the count had been correct. During the evening narcotic count RPN #133 and #134 identified that the narcotic count was missing a one half tablet of a controlled substance and had altered the narcotic count sheet's previous entry with an inaccurate amount of remaining half tablets. The next day, upon discovering that their signed count sheet had been altered, RPN #115 notified the home of the missing narcotic. The narcotic was never recovered.

During observations of the afternoon shift change narcotic count on August 8, 2016, RPN #135 and RPN #136, stated that narcotic counts were always done with two registered staff present and that if they became aware of any missing controlled substance, they would immediately notify the RN supervisor.

A review of the home's policy titled, "Combined Individual Monitored Medication Record with Shift Count- 6-7" last reviewed January 2014, indicated that at shift change, two registered staff (leaving and arriving), together; counted the actual quantity of medications remaining; confirmed the actual quantity was the same as the amount recorded on the last entry; and recorded the date, time and quantity of the medications and sign. The policy also indicated that any discrepancies were to be reported to the DOC (or delegate) immediately.

During an interview with the ADOC on August 9, 2016, they verified that RPNs #134 and #115 had not performed the narcotic count together, that RPNs #134 and #133 had identified a discrepancy in the narcotic count and had altered the narcotic count sheet and had not reported the discrepancy to the RN supervisor. The ADOC stated that the three RPNs identified had not complied with the home's policy. (609)

2. Inspector #543 reviewed a critical incident (CI), submitted to the Director in July, 2016, regarding the unexpected death of resident #001.

According to the report, resident #001 was in the dining room, was choking on their food. The CI report described that the Nurse in Charge was called, and observed that the resident was not responding. Paramedics were called for assistance, CPR had been initiated by staff in the home, and halted by paramedics. The paramedics reassessed the resident, whose vital signs were

absent.

A review of the home's "Emergency Procedures: Suctioning of the Airway- CLIN-04-03-03" policy identified that each facility must have at least one suction catheter, collecting bottle, tubing and suction machine easily accessible and in optimum working condition and available at all times for emergency use.

A review of the home's "Emergency Procedures: Suctioning of the Airway- CLIN-04-03-05A" policy identified that suctioning equipment would be stored in a place which was well known and accessible to all staff. The suction equipment would not be stored in a locked area.

During an interview with RPN #102, they stated, that a PSW was looking for a suction machine in the dining room and there was none (both were in the medication room). When they did get the suction machine it was not functional, and they had to get another one.

During an interview with PSW #104, they stated that the day of the incident where resident #001 choked in the dining room, they could not locate the suction machine that was normally kept there.

During an interview with PSW #105, they stated that they called out for a suction machine, which was usually in the corner in the dining room, but it was not there that day. They stated that another staff member went to the medication room, and got another suction machine, but that machine was missing pieces of tubing.

During an interview with RPN #106, they stated that the RNs arrived on the floor and called for a suction machine. When the suction machine was given to the RN it had not been equipped with the proper tubing, therefore, they had to wait for another suction machine. This RPN confirmed that each unit was supposed to have one suction machine in the medication room and one in dining room.

During an interview with the DOC, they stated that there should always be a suction machine kept in the medication room and that one should be kept in the dining room. The DOC also verified that the suction machine that they had taken from the medication room did not have the proper tubing.

A review of the home's "Emergency Procedures: Aid to Choking- CLIN-04-01-

03" policy identified that regardless of the status and level of the individual Advance Directives, residents who choke would receive appropriate intervention aimed at relieving the airway obstruction. Registered Nurses and Registered Practical Nurses must successfully demonstrate competence in adult foreign-body airway obstruction, including complete airway obstruction on orientation and annually thereafter. All Care Aides and Recreational and Rehabilitation Aides must successfully demonstrate safe feeding techniques and complete airway obstruction (conscious victim) on orientation and annually thereafter.

On July 27, 2016, the Inspector was approached by the DOC, who stated that the home did not require non registered staff members (PSWs) to be certified in CPR. Some of the PSWs had provided proof of certification when hired, but it was not tracked as it was not a requirement.

On July 27, 2016, the Inspector spoke with the Administrator who confirmed that the home had not provided annual training related to choking and suctioning on an annual basis. They also verified that conversations had been ongoing with the management team related to the gap in training with regards to suctioning of residents.

According to the LTCHA 2007, s. 87 (1) (a), every licensee of a long-term care home shall ensure that there are emergency plans in place for the home that comply with the regulations, including, measures for dealing with emergencies.

3. Inspector #543 reviewed the home's daily Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW) planned schedules for July, 2016. This document identified that several of the floors were working short staffed. Each of the units was short one PSW.

A review of the home's "Staffing Patterns: Staffing- NURS-02-02-01" policy identified that the nursing department was staffed on current budget, resident classification (levels of care), and number of units. This policy also stated that staffing patterns may have to be adapted according to resident needs, and that staffing patterns would be reviewed on a regular basis and at least once per year.

In an interview with PSW #105, they stated that resident #001 had not been supervised at the meal time. They verified that the floor was working in Plan B, short one PSW. They stated that resident #001 was seated in an area in the

dining room where nobody could directly see the resident's face. The PSW further stated that staff were working short a PSW, and normally the RPN would have been in resident #001's section but they had been serving other residents. PSW #105 indicated that usually when a floor was short staffed, a PSW from other florrs would come to with the meal service; however on that day in particular that had not occurred.

In an interview with PSW #104, they stated it was the meal service and staff were working in Plan B, short a PSW. They indicated that another PSW was getting up to grab a dessert and noted that resident #001 was not well.

In an interview with the DOC Clerk #114, they verified that the staff were working short staffed on that day in July, 2016. They also indicated that other floors were also short staffed that day.

In an interview with the DOC, they verified that on on that day in July, 2016, the dining room was working short staffed. They also verified that the RPN had not been in the dining room as they were pulled from the dining room to receive a medication delivery.

According to O. Reg. 79/10, s. 31, every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2). The staffing plan must, provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.

The decision to issue this compliance order was based on the previous history of voluntary plan of correction from inspections #2016_391603_0007 and #2015_391603_0024, the severity identified actual harm and the scope in this case, is widespread as the home's policies affect the safety, well-being, and quality of life of all residents.
(543)

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Order / Ordre :

The licensee shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

Grounds / Motifs :

1. The licensee has failed to ensure that that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A CI report, that was submitted to the Director in July, 2016, described the unexpected death of resident #001.

According to the CI report, resident #001 was in the dining room, was choking on their food. The CI report described that the Nurse in Charge was called, and observed that the resident was not responding. Paramedics were called for assistance, CPR had been initiated by staff in the home, and halted by paramedics. The paramedics reassessed the resident, whose vital signs were absent.

During an interview with PSW #104, they stated that the day of the incident they could not locate the suction machine that was normally kept there.

During an interview with PSW #105, they stated that they called out for a suction machine, which was usually stored in the corner of the dining room, but it was not there that day. Another staff member went to medication room, and got another suction machine, but that machine was missing pieces of tubing.

During an interview with RPN #106 they stated that the RNs arrived on the floor and called for a suction machine. When the suction machine was given to the RN it had not been equipped with the proper tubing therefore, they had to wait for another suction machine.

During an interview with the DOC, they stated that there should always be a suction machine kept in the medication room and that one should be kept in the dining room. The DOC also verified that the suction machine that they had taken from the medication room did not have the proper tubing.

The decision to issue this compliance order was based on the previous history of one or more unrelated non-compliances in the last three years, the severity identified actual harm and a scope that was isolated to one resident. (543)

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 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 25th day of October, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tiffany Boucher

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