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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Jun 30, 2016;	2016_246196_0005 (A1)	006644-16	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET P.O. BOX 3251 THUNDER BAY ON P7B 5G7

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

HOGARTH RIVERVIEW MANOR
300 LILLIE STREET THUNDER BAY ON P7C 4Y7

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Order #002 was extended to August 31, 2016, at the request of the Licensee.

Issued on this 30 day of June 2016 (A1)

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

Original report signed by the inspector.

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

LAUREN TENHUNEN (196) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 17, 18, 19, 20, 21, 24, 29, 30, 31, April 1, 2016

Additional complaint logs inspected related to resident care concerns, water temperature and hot water shortage, staffing, maintenance, laundry and home structure concerns.

During the course of the inspection, a walk through of resident home areas was conducted, interactions between staff members and residents were observed, the provision of care and services to residents were observed, the health care records for several residents and various home policies and procedures were reviewed, several employee files and home's incident reports and the home's complaint logs were reviewed.

This Complaint inspection was conducted concurrently with a Follow up inspection #2016_246196_0006 and with a Critical Incident System inspection #2016_246196_0007.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Managers, Manager of Regional Behavioural Services, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Environmental Services Manager (ESM), Manager of Food Services, Food

Service Supervisors (FSS), Manager of Employee Relations, Dietary Aides (DA), Housekeeping Aides (HA), Staffing Coordinator, RAI Coordinators, Coordinator of Volunteer Services, Laundry Supervisor, Unit Clerks, Residents and Family Members.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Falls Prevention

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

Training and Orientation

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

- **15 WN(s)**
- **7 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 LTCHA, 2007, 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following right of residents were fully respected and promoted: 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.

In March 2016, a complaint was received by the Director which outlined an incident in which resident #001 had been exposed to loud construction noise in close proximity to their room.

The health care records for resident #001 were reviewed and the plan of care identified this resident as having specific care needs for their medical condition.

An interview was conducted with the DOC regarding the construction noise that had occurred on this particular Resident Home Area. They reported that the work on a spa had started at approximately 1030 or 1100hrs on the date of complaint and included the use of a jackhammer which resulted in loud noise and vibrations. When a complaint had been received from a family member of resident #001 at approximately noon the work was stopped. They also reported that some of the

staff and residents were upset as a result of the noise and some family members had moved their loved ones to the dining room and common areas.

An interview was conducted with a family member of resident #015, and they reported that the noise in the spa was "unbearable" and very loud. They went on to report, that the noise started before lunch and then into the afternoon and that neither the resident nor the family were given notification that this was going to occur. In addition, they reported that as the noise was happening, no one approached them about the noise and it was not until they approached Clinical Manager #102 and told them the noise was "unacceptable" that the family took the resident out of the room and into another area.

In addition, the DOC reported that building services were aware of the impending renovation and construction work but the date and times had not been communicated to the Clinical Managers. As a result, residents and families were unaware of the work and noise that would ensue as a result of the spa room renovations despite the contractor having performed a test on an unoccupied unit of the home, the previous week. [s. 3. (1) 1.]

2. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Three complaints regarding the availability of hot water in the home were received by the Director.

On March 18, 2016, an interview was conducted with the Environmental Services Manager (ESM) regarding the availability of hot water in the home. They reported that the issues with hot water had improved, they were watching it closely and that engineers were to determine whether there was a need for an additional water heater or a storage tank in the home. They confirmed that there had been complaints from staff and that usually between 0800 and 1000hrs and at supper time there was a demand for hot water and therefore there was a drop in the temperature of the water. In addition, they reported that some resident rooms had cold water getting into the hot water and by making an adjustment and change the mixing valve the problem was rectified.

The maintenance record book for a Resident Home Area (RHA) was reviewed by the Inspector.

On February 9, 12 and 15, 2016, one resident room was noted as not having hot water.
On February 26, 2016, three resident rooms and the housekeeping room was noted as not having hot water.
On March 5, 2016, the spa sink water and the housekeeping room was noted as not having hot water.
On March 10, 2016, no hot water was available in three resident rooms and in a housekeeping room .

According to PSW #115 and RPN #114 on March 19, 2016, two resident rooms lacked hot water regardless of how long the water has run.

The maintenance record book for another RHA was reviewed by the Inspector. On March 18, 2016, three resident rooms were noted as not having hot water.

An interview was conducted with PSWs #132, 133 and 134, on the second specified RHA on March 20, 2016, regarding the availability of hot water. These direct care staff members reported that it took a long time to fill a basin with hot water if the water pressure was low or if there was a lack of hot water and it made the provision of resident care difficult. Inspector accompanied PSW #132, to a resident room and observed the hot water tap turned on full and only a trickle of luke warm water came out. PSW #132 reported that staff would record in the maintenance book at the nursing desk and then the maintenance staff will come and do repairs as needed.

On March 31, 2016, at 0835hrs, an interview was conducted with RN #109 and they reported that a resident room did not have hot water that morning. They had contacted the maintenance department by phone to inform them about the lack of hot water.

On April 1, 2016, an interview was conducted with the ESM (Environmental Services Manager) regarding concerns with hot water and water pressure in resident washrooms on the second specified RHA. They reported that maintenance staff had gone through that particular RHA in entirety and addressed the water temperature and water pressure in resident washrooms. They then reported they were unaware of concerns that had arose the previous day and that a work order was expected to be completed for it to be addressed. [s. 3. (1) 4.]

3. The licensee failed to ensure that the following rights of residents were fully respected and promoted: Every resident has the right to be told who was responsible for and who was providing the resident's direct care.

A complaint was received by the Director in March 2016, regarding the qualifications of a particular staff member #112. According to the complaint, this staff member had provided medications to resident #001, yet had identified themselves to the complainant as a PSW. The complaint also noted that this staff member had a name tag which identified themselves as a PSW and when asked by the complainant if they were the RPN, they said "no, the PSW".

An interview was conducted with the DOC regarding the qualifications of staff member #112. The DOC reported that this person was from an agency and was identified on the staffing list as both a PSW and RPN. They also reported that agency staff get an identification tag which included their name and designation and they were unsure why this staff did not have a name tag with RPN on it. Further they added, that the agency had been notified as was the Human Resources department at the home to obtain a new name tag that would identify this staff as a RPN as well.

An online search was completed by the Inspector and determined this staff was registered with the College of Nurses of Ontario as having a RPN designation and was "Entitled to Practise with no Restrictions".

An interview was conducted with the Staffing Coordinator #110 regarding an agency staff member #112. They confirmed that, on this particular date, staff member #112 was scheduled to work as a PSW, but the unit was short a RPN. As a result of the unit being short a RPN, agency staff member #112 was placed into the registered practical nurse role and out of the PSW role. [s. 3. (1) 7.]

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 that ensures that every resident is told who is responsible for and who is providing the resident's direct care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the pain management program must, at a minimum, provided for the following: Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

A complaint was received by the Director outlining concerns with pain management for resident #006.

The health care records for resident #006 were reviewed by Inspector #616 for information related to orders for pain management. A physician's order for an

analgesic was noted. Changes to the order related to the administration method, adjustments in the medication dose, and frequency of the pain medication administration, was documented throughout a two month period in 2015.

The Resident Assessment Protocol (RAP) of the Resident Assessment Instrument Minimum Data Set (RAI-MDS) was completed related to a significant change in the resident's status. The pain RAP indicated the resident was at high risk for pain, with key issues that contributed to the RAP was poor pain management and discomfort. The care planning decision was to maintain comfort, and maintain effective pain management.

The resident's care plan in effect identified pain with an intervention to administer medication as ordered and assess effectiveness of medications given.

Inspector #616 reviewed progress notes related to pain medication and monitoring of effectiveness during two periods in the two months reviewed. According to the progress notes linked to the electronic Medication Administration Record (e-MAR), there was no documentation of the medication effectiveness of the analgesic on 10 instances, with two instances on the same day.

The home's Pain Management Program, dated December 2012, referred to the Pain Management Toolkit, dated December 2012. Within the toolkit, section "Interprofessional Team Monitoring" identified that the Registered Nursing Staff would implement strategies to effectively manage pain including (but not limited to) pharmacological interventions. Registered staff were to document the effectiveness of the interventions.

During interviews with RPN #113 and RPN #114, they verified to Inspector #616 that pain assessments were to be completed after as needed (prn) medication was administered. They further reported that the e-MAR prompts staff to complete a follow up pain assessment one hour after administration for effectiveness of the pain medication. [s. 52. (1) 4.]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

In March 2016, an interview was conducted with the SDM of resident #012. They identified that they had requested two assistive devices to help with the resident with an activity of daily living. Observations of the resident's living area were done and one of the assistive devices was not in place, and the other was demonstrated

by the SDM to be inadequate for resident #012's use.

The complaint binder for the this particular resident's home area was reviewed and included documentation by Clinical Manager #103. The information noted a discussion with the SDM of resident #012 and with the DOC regarding the two assistive devices and that a maintenance requisition was completed for same.

The maintenance log book was reviewed and indicated two dates in which the first assistive device was requested for resident #012 and three dates which the other assistive device was referenced for this resident.

An interview was conducted with PSW #115. They reported that resident #012 had specific care needs, the resident's family member would also assist the resident, and had reported that the assistive device made available was ineffective for the resident's use. [s. 6. (5)]

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

In mid-March 2016, resident #012's bed was observed and had bilateral upper bed rails in place. The SDM reported to the Inspector that they had requested full bed rails for this resident's safety approximately 30 days prior and they had not been installed yet. At the end of March 2016, resident #012's bed was observed and did not have full bed rails in place.

The health care records for resident #012 were reviewed for information regarding bed rails. In February 2016, a physician's orders included an order for full bed rails and the consent for the bed rails had been signed by the SDM. The current care plan, printed at the end of March, 2016, under the focus of "restraints" indicated that "side rails have not arrived yet, and will be put on by maintenance". [s. 6. (7)]

3. The licensee failed to ensure that the following were documented: The provision of the care set out in the plan of care.

The health care records for resident #001 were reviewed for information regarding the provision of food and fluids. The care plan that was in effect at the time of admission to the home indicated the level of assistance that this resident was to have under the focus of eating.

A copy of the Point of Care (POC) dietary reports, over an approximate five week period, as completed by the PSWs, which indicated the provision of meals, snacks and beverages to resident #001, was provided to the Inspector by Clinical Manager #102. In addition, copies of additional care documentation, and the intake and output records for dietary intakes, were reviewed.

Resident #001's intake for the following meals and snacks was not documented on the Point of Care "dietary report", nor the additional care documentation records:

-breakfast food and beverage intake was not documented on six days,

-AM snack intake was not documented on 18 days,

-lunch meal intake was not documented on six days,

-PM snack intake was not documented on eight days,

-supper meal and beverage intake was not documented on five days, and,

on six days, the HS snack for resident #001 was not documented on the Point of Care "dietary report" nor the additional care documentation records. [s. 6. (9) 1.]

4. The licensee shall ensure that the following were documented: The provision of the care set out in the plan of care.

The care plan for resident #001 was reviewed for information on the required care needs. The plan identified care needs to include the activities of daily living, dressing, eating, toileting, transferring, bed mobility, walking in room or in corridor, and mode of locomotion.

A copy of the Point of Care (POC) flow sheets as completed by the PSWs, which indicated the provision of care to resident #001, was provided to the Inspector by Clinical Manager #102. In addition, copies of the additional care documentation records were reviewed.

The Point of Care (POC) online "observation/flow sheet monitoring form" from for an approximate one month period was reviewed and included areas to document the provision of: bathing, bed mobility, dressing, eating, locomotion on and off unit, personal hygiene, toileting, transferring, walk in corridor and walk in room. The

additional care documentation records for this period, as well as another 12 day period were reviewed.

On one day shift during the reviewed periods, the provision of care, specifically bathing, dressing, eating and personal hygiene was not documented on the additional care documentation records, nor in the POC "observation/flow sheet monitoring form" online.

On another day shift, the provision of care, specifically eating and dressing was not documented on the additional care documentation records, nor in the POC "observation/flow sheet monitoring form" online.

On a different day shift in the reviewed periods, the provision of care, specifically eating was not documented on the additional care documentation records, nor in the POC "observation/flow sheet monitoring form" online.

On two evening shifts, the provision of care, specifically bathing, eating, dressing, personal hygiene and toileting, was not documented on the additional care documentation records, nor in the POC "observation/flow sheet monitoring form" online. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, the plan of care was provided to the resident as specified in the plan and the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that written complaints concerning the care of a resident or the operation of the long-term care home were immediately forwarded to the Director.

In March, 2016, an email outlining care concerns regarding resident #001 had been received by the Clinical Manager #102 and copied to the DOC.

Thirteen days later, an email from the complainant regarding care concerns and resident #001 had been received by the DOC.

An interview was conducted with the DOC regarding the email complaints. They reported that the emails that had been received from a family member of resident #001 were related to questions that they had and were not complaints.

An interview was conducted with the Administrator and they reported that neither complaint emails had been forwarded to the Director. [s. 22. (1)]

2. A complaint had been received by the Director regarding care concerns of resident #004 and operation of the home.

According to the complainant, they had given a written letter of complaint to Clinical Manager #103 a few days after their spouse had been admitted to the home and had not had a response back about all their concerns. The complainant reported that their complaint letter included concerns with food temperatures, the flooring lifting up, spouse not having a bath for nine days, fire drills and staff response to the drill, concern about another resident having a fall in the dining room and staff supervision in the dining room. In addition, the complainant reported to the Inspector that on the last day of Clinical Manager #103's employment in the home and in the presence of the incoming acting Clinical Manager #105, they reminded them of the complaint letter and both had acknowledged same.

The Critical Incident System (CIS) was reviewed and a copy of the written complaint provided to the home by the complainant was not received by the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that written complaints concerning the care of a resident or the operation of the long-term care home are immediately forwarded to the Director, to be implemented voluntarily.

WN #5: 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,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, each resident who was incontinent and had been assessed as being potentially continent or continent some of the time received the assistance and support from staff to become continent or continent some of the time.

An interview was conducted with the SDM of resident #012. At a previous home, they were able to assist the resident with an activity of daily living but are no longer able to do this as the assistive device was currently positioned incorrectly and another assistive device was not made available. They identified that they had requested two different assistive devices to aid the resident with an activity of daily living. Observations of the resident's living space were done and one assistive device was not in place, and the other assistive device was demonstrated by the

SDM to be inadequate for resident #012's use.

The complaint binder for the resident's home area was reviewed and included documentation dated March 2016, by Clinical Manager #103. The information noted a discussion with the SDM of resident #012 and with the DOC regarding these two assistive devices and that a maintenance requisition was completed for the same. In addition, the documentation also included specific care was to be established and a care plan was to be created for resident #012.

The health care records for resident #012 were reviewed for information regarding a specific care need. A completed assessment indicated the level of staff assistance required by the resident, also indicated the family would assist the resident with this care, and supplies and equipment that were required by the resident. Another assessment also indicated the resident's care needs. The current care plan identified the level of staff assistance with this care and included the frequency of care by staff.

The maintenance log book was reviewed and indicated two dates in which an assistive device was requested for resident #012 and three dates on which another assistive device was referenced for this resident.

An interview was conducted with PSW #115. They reported that resident #012 had specific care needs, the resident's family member would also assist the resident, and had reported that the assistive device made available was ineffective for the resident's use. They reported that this resident had not received this specific care from staff and was not provided the required equipment. [s. 51. (2) (d)]

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 that ensures that resident #012 who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home had a dining and snack service that included, at a minimum, the following elements: Monitoring of all residents during meals.

The Dietary Aide (DA) on a resident home area reported to the Inspector resident #018 was eating the wrong texture food in the dining room. They also reported that they had removed the plate of food. There were no staff present in the dining room, there was a family member feeding a resident at another table and also resident #020 was eating dessert.

An interview was conducted with the DA and they identified that resident #018 was to have a minced diet and they had observed them eating handfuls of cut up, regular texture food. In addition, they reported that the resident was eating the

leftovers from resident #019, who normally sat at that table.

After ten minutes, two PSWs came to the dining room and it was determined that the RPN and the other PSW were off the unit on their supper break. Resident #020 was still eating their dessert and was identified as requiring supervision.

The kardex for resident #018 was reviewed and identified that this resident was to receive a pureed texture diet, required one assist of staff with meals and staff were to be alert for choke risk.

The kardex for resident #020 was reviewed and identified that this resident required supervision for all meals and snacks.

The Inspector reported the lack of supervision in the dining room to the RPN, RN and to the DOC.

An interview was conducted with Clinical Manager #102 and they reported that they had been made aware of the two residents on this particular home area that had been eating in the dining room and were not monitored by staff. They reported that the expectation was that staff were to be in the dining room at any time that a resident was consuming their meal. [s. 73. (1) 4.]

2. The licensee failed to ensure that residents who required assistance with eating or drinking were served a meal until someone was available to provide the assistance required by the resident.

The Inspector observed two residents seated at a dining table on a resident home area that had been served their supper meal and staff were not available to provide assistance and neither resident attempted to feed themselves. Resident #021 had a plate with lasagna, bread and vegetables in front of them on the table and resident #022 had a plate with a minced meal on the table in front of them.

Resident #021 and resident #022 were observed to receive assistance from PSW #131, 14 minutes after meal plates were placed down on the table in front of them. According to this PSW, both resident #021 and #022 required full assistance of staff with their meals.

The kardex as found in the binder identified resident #021 as "May need to be fed by staff at times that they will not feed self".

The kardex as found in the binder identified resident #022 as "total assistance with meals". [s. 73. (2) (b)]

3. Resident #024 reported to the Inspector that they had been served their supper meal and staff were not available to provide assistance to them for at least 10 minutes. Resident #024 reported and the Inspector observed, that they required full assistance as they were unable to feed themselves due to a medical condition. They also reported that frequently their meal was placed in front of them on the dining table and staff were not available to assist at that time. [s. 73. (2) (b)]

4. The Inspector observed resident #013 and resident #025 seated at a dining table on a resident home area and each resident had a plate of pureed food on the table in front of them and staff were not available to provide assistance.

PSW #117 was seated at a different table and assisted another resident with their breakfast meal and when asked about the plates in front of resident #013 and #025, they reported that they had been on the table for three minutes. According to staff, both of these residents require full assistance with their meal. The remainder of the PSW staff were observed to continue to get meals from the servery and distribute to residents.

Fourteen minutes after the initial observations, PSW #118 was observed to heat the plate that was in front of resident #025 in the microwave and proceeded to feed the resident and another PSW was observed to do the same with resident #013's plate and then provide assistance with the meal. [s. 73. (2) (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 that ensures that the dining and snack service that includes monitoring of all residents during meals and that residents who require assistance with eating or drinking are not served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A missing or unaccounted for controlled substance.

A complaint was received by the Director outlining concerns with missing transdermal analgesic patches for resident #006.

On March 29, 2016, an interview was conducted with resident #006's SDM and they reported that on several occasions during a five month period in 2015, the resident's transdermal analgesic patch was missing and that they had reported it to the Clinical Manager for investigation.

On March 31, 2016, an interview was conducted with Clinical Manager #102 and the Administrator regarding an investigation into missing transdermal analgesic patches for resident #006. The Administrator reported that if they thought there was a problem with staff and the patches, it would have been reported.

Clinical Manager #102 provided a copy of the home's online medication incident reports for resident #006 for the five month time period in 2015. Four incidents were documented in which resident #006's transdermal analgesic was missing and unaccounted for, twice in one month, once during the following month, and once in the last month.

A review of the Critical Incident System was done and the Director was not informed of these incidents of missing and unaccounted for controlled substances. [s. 107. (3) 3.]

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 that ensures that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #8: 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 failed to ensure that drugs were stored in an area or a medication cart, that was secure and locked.

On March 30, 2016 at 1115hrs, a resident care cart was observed on a resident home area with a plastic container of prescription topical creams on the cart within reach of anyone that may pass by.

According to PSW #119, the container with the creams are kept on the cart until the end of the day and then locked up. Spoke with RPN #120 and they reported that the container was to be kept in the medication room locked up or in the resident care cart locked up. An interview was conducted with PSW #115 and they reported that creams are to be locked up on the resident care cart and the lock was broken on the care cart.

The plastic container was reviewed by the Inspector and contained the following pharmacy labeled topical medications:
- two topical medications for resident #026
- one topical medication for resident #027
- one topical medication for resident #028
- one topical medication for resident #029
- one topical medication for resident #030
- one topical medication for resident #031 [s. 129. (1) (a) (ii)]

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 that ensures that drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that, a care conference of the interdisciplinary team providing a resident's care was held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

On March 30, 2016, Inspector #616 spoke with RPN #122 where they reported that they had facilitated two resident care conferences recently where they were the only member of the interdisciplinary team in attendance, along with the family.

The progress notes related to a care conference from a randomly selected resident #032, were reviewed. The note indicated that a care conference had been scheduled in March 2016, and that the RPN and Recreation staff member had attended. No other interdisciplinary team members were identified as being in attendance. [s. 27. (1) (a)]

2. On March 17, 2016, an interview was conducted with the SDM of resident #012 and they reported that at a recent care conference for the resident, only the RN and a staff member from the Recreation Department was present. The SDM reported that the care conference was rescheduled for a later date so that more

interdisciplinary staff members from the home could attend.

The progress notes related to resident #012's care conference that had been scheduled for March 2016, identified that the SDM was not pleased that other departments were not able to attend the care conference and had refused to discuss anything without all departments available and requested to reschedule. No other interdisciplinary team members were identified as being in attendance. [s. 27. (1) (a)]

3. An interview was conducted with the DOC regarding a policy on care conferences for residents. They provided a copy of the "Resident and Family Handbook" which on page 17 identified that a care conference meeting with the interprofessional team would be scheduled to discuss care needs and to set personal goals. On page 26 of the same handbook, members of the interprofessional care team were listed and included the Director, Managers, nursing team, Medical Director, building services, clerical, Registered Dietitian, Food services staff, Financial services, Pharmacist, Physiotherapist, Resident Engagement Coordinator, Spiritual Care Associate, Therapeutic Recreationists, etc. [s. 27. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis.

On two occasions resident #016 was observed with unshaven facial hair.

The current care plan indicated under the focus of "Personal Hygiene, the expected outcome was "to be neat, clean and odour free" and "client to be clean and well groomed by staff at all times" and the interventions noted "one staff" assistance.

An interview was conducted with PSW #123 and they reported resident #016 was not resistive to care and that residents should be shaved daily as part of their personal hygiene.

An interview was conducted with PSW #119 and they reported that they provided care to resident #016 this morning and there was no time to provide a shave to them as the call bells were ringing and residents needed care. [s. 32.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A complaint was received by the Director regarding the provision of bathing to resident #004 in the home. The complainant reported that the resident was not provided with a bath over a nine day period.

Inspector reviewed the health care records for resident #004. The online copy of "observation/flow sheet monitoring form" from the time of admission to the home over an approximate five week period, was reviewed. There was a documented resident bath refusal in February 2016, which resulted in resident #004 not having a bath for seven day period. In addition, there was a span of twelve days in which a bath was not documented in March 2016. [s. 33. (1)]

2. A complaint was received by the Director regarding the bathing of two specific residents in the home.

The health care records for resident #014 were reviewed for bathing information. The "Observation/Flow Sheet Monitoring Form" over a one month period was reviewed with Clinical Manager #102 and it was determined that this resident had three tub baths and eight bed baths during this time. The current care plan was reviewed and identified the resident's bath days and time, and the resident's preference was listed as tub bath. Clinical Manager #102 was questioned as to why bed baths were being done as this was not the residents preference and they reported they were not aware of the reason for this.

The health care records for resident #015 were reviewed for bathing information. The "Observation/Flow Sheet Monitoring Form" over a one month period was reviewed with Clinical Manager #102 and it was determined that this resident had four tub baths and seven bed baths and one resident refusal during this time. The current care plan was reviewed and identified the resident's bath days and time, their preference was a tub bath and if refuses, then bed bath. [s. 33. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received fingernail care, including the cutting of fingernails.

A complaint was received by the Director regarding the finger nail care of two specific residents in the home.

On a resident home area, resident #013 was observed with finger nails that were long, uncut with jagged edges, and soiled with brown/black debris under the nail. Another resident, identified as resident #015 was observed with long fingernails, jagged edges and dark coloured debris under the nail and around the cuticles of nails.

The Clinical Manager #102 observed with the Inspector that resident #014 had long uncut fingernails and that #015 had long uncut fingernails with debris under them.

The health care records for resident #013 were reviewed for nail care information. The "Observation/Flow Sheet Monitoring Form" over a month period in 2016 February to March, 2016, was reviewed with Clinical Manager #102 and it was determined that during this one month period, nail care was documented as provided on one occurrence.

The health care records for resident #014 were reviewed for nail care information. The "Observation/Flow Sheet Monitoring Form" over a one month period was reviewed with Clinical Manager #102 and it was determined that during time, nail care was documented as provided on one occurrence. [s. 35. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(a) policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service; O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had and that the staff of the home complied with, policies and procedures for the safe operation and cleaning of equipment related to the food production system and dining and snack service.

A complaint was received by the Director regarding the cleaning and disinfecting of resident dining tables on a RHA.

On March 19, 2016, at 1410hrs, the eight dining tables in the dining room on a RHA were observed to have various amounts of food particles, crumbs and debris on them. According to the complainant, on this same day, the tables had been wiped down after the lunch service yet still had food on them. The same dining tables were observed by the Inspector at 1620hrs, and were set with napkins and cutlery and the food particles, crumbs and debris were unchanged.

At 1745hrs, after the supper meal, Dietary Aide #124 was observed cleaning the dining tables with a cloth and a pail with soapy solution. Then they sprayed a bottle of solution labeled "Oasis 137" onto the surface of the tables and wiped with a different cloth. An interview was conducted with DA #124 and they reported that this was the protocol for wiping the dining tables.

On March 17, 2016 at 1025hrs, Dietary Aide #125 was observed cleaning the dining tables with a cloth and a pail with soapy solution. DA #125 reported that the process for cleaning the dining tables was to use a cloth and pail with disinfectant and to go from table to table and wipe them down.

On March 29, 2016, an interview was conducted with Food Service Supervisor (FSS) #126 with regard to the process used by the dietary aides to clean the resident dining tables. They reported that the tables were to be washed with a cloth and soapy water and then sanitized with "Oasis 146" that is to be sprayed on and let it sit for 30 seconds. It can be left to dry on its own or be wiped off.

The FSS provided a copy of the dietary services "safe food preparation and cleaning technique", April 2015 and a copy of "Ecolab" cleaning and sanitizing procedures of counters and tabletops and reported that these are to be followed by staff to clean the resident dining tables. [s. 72. (7) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

s. 75. (2) A person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a registered dietitian. O. Reg. 79/10, s. 75 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a person hired as a nutrition manager after the coming into force of this section must be an active member of the Canadian Society of Nutrition Management or a Registered Dietitian.

A complaint was received by the Director outlining concerns that the Nutrition Manager did not have the appropriate qualifications.

An interview was conducted with Food Services Supervisor #126 and they reported that they are an active member of the Canadian Society of Nutrition Management (CSNM) and provided a copy of certificate.

An interview was conducted with Food Services Supervisor (FSS) #127 reported that they have a student designation membership with the Canadian Society of Nutrition Management (CSNM) and they are currently enrolled in online courses. In addition, they reported that both themselves and FSS #126 do the same jobs at the home.

An interview was conducted with Manager of Employee Relations #104 and they confirmed that FSS #126 and FSS #127 were the Nutrition Managers as identified in the LTCHA 2007. A copy of the licensee's job description for the position of Food Service Supervisor was reviewed and it identified that the qualifications for this position was "member of the Canadian Society of Nutrition Management". [s. 75. (2)]

WN #15: The Licensee has failed to comply with LTCHA, 2007, s. 77. Orientation for volunteers
Every licensee of a long-term care home shall develop an orientation for volunteers that includes information on,
(a) the Residents' Bill of Rights;
(b) the long-term care home's mission statement;
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
(d) the duty under section 24 to make mandatory reports;
(e) fire safety and universal infection control practices;
(f) any other areas provided for in the regulations; and
(g) the protections afforded by section 26. 2007, c. 8, s. 77.

Findings/Faits saillants :

1. The licensee has failed to ensure that an orientation for volunteers was developed that included information on the the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protections under section 26.

A complaint was received by the Director regarding the training that was provided to volunteers in the home.

An interview was conducted with Coordinator of Volunteer Services #128 on March 30, 2016, regarding the provision of training and supervision of volunteers. They reported that volunteer #130 had attended mandatory orientation for volunteers in November 2015 but the training did not include the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24 nor whistle blowing protection. [s. 77.]

Issued on this 30 day of June 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : LAUREN TENHUNEN (196) - (A1)

Inspection No. / No de l'inspection : 2016_246196_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 006644-16 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Jun 30, 2016;(A1)

Licensee / Titulaire de permis :
ST. JOSEPH'S CARE GROUP
35 NORTH ALGOMA STREET, P.O. BOX 3251,
THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD :
HOGARTH RIVERVIEW MANOR
300 LILLIE STREET, THUNDER BAY, ON,
P7C-4Y7

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To ST. JOSEPH'S CARE GROUP, 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. 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.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
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.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall ensure that the rights of residents are fully respected and promoted.

Specifically:

a) that residents are notified of, and steps are taken to minimize, any impending construction which may negatively impact a resident's quality of life; and
b) that residents are notified of, and contingency plans are in place to address, any environmental systems that may adversely impact resident care.

Grounds / Motifs :

1. The licensee failed to ensure that the following right of residents were fully respected and promoted: 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.

In March 2016, a complaint was received by the Director which outlined an incident in which resident #001 had been exposed to loud construction noise in close proximity to their room.

The health care records for resident #001 were reviewed and the plan of care identified this resident as having specific care needs for their medical condition.

An interview was conducted with the DOC regarding the construction noise that had occurred on this particular Resident Home Area. They reported that the work on a spa had started at approximately 1030 or 1100hrs on the date of complaint and included the use of a jackhammer which resulted in loud noise and vibrations. When a complaint had been received from a family member of resident #001 at approximately noon the work was stopped. They also reported that some of the staff and residents were upset as a result of the noise and some family members had moved their loved ones to the dining room and common areas.

An interview was conducted with a family member of resident #015, and they reported that the noise in the spa was "unbearable" and very loud. They went on to report, that the noise started before lunch and then into the afternoon and that neither the resident nor the family were given notification that this was going to occur. In addition, they reported that as the noise was happening, no one approached them about the noise and it was not until they approached Clinical Manager #102 and told them the noise was "unacceptable" that the family took the resident out of the room and into another area.

In addition, the DOC reported that building services were aware of the impending renovation and construction work but the date and times had not been communicated to the Clinical Managers. As a result, residents and families were unaware of the work and noise that would ensue as a result of the spa room renovations despite the contractor having performed a test on an unoccupied unit of the home, the previous week. [s. 3. (1) 1.] (196)

2. The licensee failed to ensure that the following rights of residents were fully

respected and promoted: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

Three complaints regarding the availability of hot water in the home were received by the Director.

On March 18, 2016, an interview was conducted with the Environmental Services Manager (ESM) regarding the availability of hot water in the home. They reported that the issues with hot water had improved, they were watching it closely and that engineers were to determine whether there was a need for an additional water heater or a storage tank in the home. They confirmed that there had been complaints from staff and that usually between 0800 and 1000hrs and at supper time there was a demand for hot water and therefore there was a drop in the temperature of the water. In addition, they reported that some resident rooms had cold water getting into the hot water and by making an adjustment and change the mixing valve the problem was rectified.

The maintenance record book for a Resident Home Area (RHA) was reviewed by the Inspector.

On February 9, 12 and 15, 2016, one resident room was noted as not having hot water.
On February 26, 2016, three resident rooms and the housekeeping room was noted as not having hot water.
On March 5, 2016, the spa sink water and the housekeeping room was noted as not having hot water.
On March 10, 2016, no hot water was available in three resident rooms and in a housekeeping room .

According to PSW #115 and RPN #114 on March 19, 2016, two resident rooms lacked hot water regardless of how long the water has run.

The maintenance record book for a second specified RHA was reviewed by the Inspector. On March 18, 2016, three resident rooms were noted as not having hot water.

An interview was conducted with PSWs #132, 133 and 134, on the second specified RHA on March 20, 2016, regarding the availability of hot water. These direct care

staff members reported that it took a long time to fill a basin with hot water if the water pressure was low or if there was a lack of hot water and it made the provision of resident care difficult. Inspector accompanied PSW #132, to a resident room and observed the hot water tap turned on full and only a trickle of luke warm water came out. PSW #132 reported that staff would record in the maintenance book at the nursing desk and then the maintenance staff will come and do repairs as needed.

On March 31, 2016, at 0835hrs, an interview was conducted with RN #109 and they reported that a resident room did not have hot water that morning. They had contacted the maintenance department by phone to inform them about the lack of hot water.

On April 1, 2016, an interview was conducted with the ESM (Environmental Services Manager) regarding concerns with hot water and water pressure in resident washrooms on the second specified RHA. They reported that maintenance staff had gone through that particular RHA in entirety and addressed the water temperature and water pressure in resident washrooms. They then reported they were unaware of concerns that had arose the previous day and that a work order was expected to be completed for it to be addressed. [s. 3. (1) 4.] (196)

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

May 27, 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. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired.
2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids.
3. Comfort care measures.
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Order / Ordre :

The licensee shall ensure that:

a). an audit is conducted of residents that are identified as experiencing pain or
having interventions in place to manage pain;
b). an individualized care plan to promote effective pain management is in place
or implemented for those residents assessed as experiencing pain or having interventions in place to manage pain;
c). training of the licensee's pain management program is provided to staff and
others who provide direct care to residents related to monitoring and documentation of the residents response to and effectiveness of pharmacological interventions; and
d). records of training content, dates of training, names of attendees and an evaluation demonstrating staff understanding of the licensee's pain management program are maintained.

Grounds / Motifs :

1. The licensee failed to ensure the pain management program must, at a minimum, provided for the following: Monitoring of residents' responses to, and the effectiveness of, the pain management strategies.

A complaint was received by the Director outlining concerns with pain management

for resident #006.

The health care records for resident #006 were reviewed by Inspector #616 for information related to orders for pain management. A physician's order for an analgesic was noted. Changes to the order related to the administration method, adjustments in the medication dose, and frequency of the pain medication administration, was documented throughout a two month period in 2015.

The Resident Assessment Protocol (RAP) of the Resident Assessment Instrument Minimum Data Set (RAI-MDS) was completed related to a significant change in the resident's status. The pain RAP indicated the resident was at high risk for pain, with key issues that contributed to the RAP was poor pain management and discomfort. The care planning decision was to maintain comfort, and maintain effective pain management.

The resident's care plan in effect identified pain with an intervention to administer medication as ordered and assess effectiveness of medications given.

Inspector #616 reviewed progress notes related to pain medication and monitoring of effectiveness during two periods in the two months reviewed. According to the progress notes linked to the electronic Medication Administration Record (e-MAR), there was no documentation of the medication effectiveness of the analgesic on 10 instances, with two instances on the same day.

The home's Pain Management Program, dated December 2012, referred to the Pain Management Toolkit, dated December 2012. Within the toolkit, section "Interprofessional Team Monitoring" identified that the Registered Nursing Staff would implement strategies to effectively manage pain including (but not limited to) pharmacological interventions. Registered staff were to document the effectiveness of the interventions.

During interviews with RPN #113 and RPN #114, they verified to Inspector #616 that pain assessments were to be completed after as needed (prn) medication was administered. They further reported that the e-MAR prompts staff to complete a follow up pain assessment one hour after administration for effectiveness of the pain medication. [s. 52. (1) 4.] (616)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 :

Aug 31, 2016(A1)

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

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

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

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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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

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
Toronto ON M5S 2B1
Télécopieur : 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 30 day of June 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LAUREN TENHUNEN - (A1)

Service Area Office /
Bureau régional de services : Sudbury