Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 1, 2017	2017_673554_0019	005010-17, 009088-17, 010163-17, 010758-17, 013200-17, 014152-17, 018475-17, 019034-17	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

KELLY BURNS (554)

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): August 01-04, and August 08-11, 2017

Intakes #005010-17, 009088-17, 010163, 17, 010758-17, 013200-17, 014152-17, 018475-17, and 019034-17.

Summary of Intakes:
1) #005010-17 - Critical Incident Report (CIR) - alleged staff to resident abuse;
2) #009088-17 - CIR - alleged staff to resident abuse;
3) #010163-17 - CIR - alleged staff to resident neglect;
4) #010758-17 - CIR - incident that causes injury to a resident for which the resident is taken to hospital and which results in a significant change in resident's health status;
5) #013200-17 - CIR - alleged staff to resident neglect;
6) #014152-17 - CIR - alleged staff to resident neglect;
7) #018475-17 - CIR - alleged staff to resident abuse;
8) #019034-17 - CIR - alleged staff to resident neglect.

Areas of Non-Compliance, under LTCHA, 2007, s. 6 (7), related to Intakes #014107-17, and #011714-17, are captured in this inspection report. Information related to these areas of non-compliance are identified in inspection report #2017_673554_0018, which was inspected concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director, Interim Director of Care, Regional Director, Associate Director of Care, Resident Services Coordinator, Environmental Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping Aide, family and residents.

During the course of the inspection, the inspector, toured the home, observed staff to resident interactions, resident to resident interactions, reviewed clinical health records, licensee's investigations related to associated CIRs, program evaluations for the 2016 Prevention of Abuse Program, and Falls Prevention Program, and reviewed licensee policies, specifically, Resident Non-Abuse Program, Fall Interventions Risk Management (FIRM) Program, Assessment Schedule, Operation of Mechanical Lifting/Transferring and Repositioning Devices, No Manual Lift Directive, Continence Care, Complaint Management, Maintaining a Safe and Secure Environment, and Communication and Response-Call Bell System.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

Findings/Faits saillants :

1. The licensee failed to ensure that the written care plan for resident #008 sets out the planned care for the resident.

Related to Intake # 010758-17:

The Associate Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Resident #008 was identified, in this CIR, as having sustained an injury of unknown origin.

Resident #008 has a history which includes cognitive impairment. Resident #008 requires extensive assistance for all activities of daily living.

The clinical health record, for resident #008, was reviewed by the inspector, with the following documented:

FRAT (Fall Risk Assessment Tool):
- Assessment (identified date) – (completed by registered nursing staff) - identifies resident #008 to be assessed at risk for falls.

Progress Notes (reviewed for an identified date):
- On an identified date – Resident #008 was noted by Personal Support Worker (PSW), to have an injury. Injury was of unknown origin.
- Two days later - Resident #008 assessed by the physician, orders received for further assessment, and orders not to weight bear. S.A.L.T (safe ambulation, lifts and transfers) assessment completed, the lift/transfer device status was changed. Resident #008 remains non-weight bearing. Diagnostic imaging identified a specific diagnosis. Resident was said to have had no recent falls, prior to this injury. Resident was transferred to hospital, for treatment.

FRAT (Fall Risk Assessment Tool):
- Assessment (identified date): (completed by registered nursing staff) – identifies resident #008 to be assessed as at risk for falls.

Written Care Plan (identified dates)
- Falls Risk focus, and/or planned care, specific to this risk was not identified in this document.

Registered Practical Nurse (RPN) #102, the Associate Director of Care, and the Executive Director indicated, to the inspector, that resident's assessed as being at risk for falls are to have a plan of care in place which identifies both the risk and interventions to decrease the fall risk.

The licensee failed to ensure that the written care plan for resident #008 sets out the planned care for the resident, specific to fall risk. [s. 6. (1) (a)]

2. The license failed to ensure that the care set out in the plan of care is based on an assessment of resident #009, and the needs of that resident.

Related to Intake #014152-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on identified date, regarding an allegation of staff to resident neglect of care. The incident occurred three days earlier and involved resident #009.

Resident #009 is cognitively well. Resident #009 requires extensive assistance for activities of daily living.

Resident Services Coordinator (RSC) indicated, to the inspector, that resident #009 requires an identified medicated treatment which is to operate continuously. RSC indicated resident #009 becomes extremely anxious if his/her required treatment runs low.

The clinical health record, for resident #009, was reviewed by the inspector, documentation details the following:

Written Care Plan (last review for an identified date):

- Impaired Respiratory Status – Interventions include, requires the use of an identified treatment (continuous/prn); notify nurse of any changes in breathing, mental status, or signs of blue tinged skin around mouth or nail beds. Goals of care include, symptoms will be minimized.
- Potential to exhibit Responsive Behaviours – easily irritated, due to declining health. Interventions include, staff to provide resident with time frames when care requests will be met and make all attempts to adhere to set times, if issues arise preventing the time frame from being kept, staff are to notify resident immediately;
- High Risk for drug related complications – Interventions include, notify nurse if any dizziness, headache or shortness of breath.

Physician's Orders: (identified date)
- Identified medicated treatment - at an identified flow rate - continuously
- Identified medicated treatment – PRN (as needed) may increase to an identified rate for symptom management for 1/2 hour then reduce back to the identified flow rate.

Progress Notes (period identified):
- On an identified date – Executive Director went to see resident #009 after receiving voice message from resident's family, stating resident wanted to see him/her (Executive Director) regarding an incident four days earlier. Resident #009 indicated to Executive Director, that his/her concern was about his/her ordered treatment. Resident #009 indicated that he/she arrived back to his/her room on an identified date/time, and found that he/she was not getting enough air, resident stated he/she rang the call bell four times and no one (staff) came. Resident indicated he/she went into the hallway and saw a personal support worker in another resident's room, he/she indicated to staff that he/she needed assistance, stating to PSW that 'this is an emergency'. Resident #009 indicated that PSW said he/she was with another resident who had returned from

hospital; resident #009 indicated to the Executive Director that the PSW continued to speak to other resident and ignored him/her. Resident #009 indicated, to the Executive Director, that he/she waited twenty minutes for the Charge Nurse to arrive, indicating to the Executive Director that the charge nurse was off the unit and on his/her break.
- Date of Incident - At identified hour (approximately an hour after identified shift began) - RPN #105 indicated an identified medication was administered to resident #009, due to complaints his/her, and was assessed at that time. (Note: there is no documentation to support that resident #009 was assessed by registered nursing staff following voicing his/her concerns to PSW)

The Executive Director indicated to the inspector, that he/she, the Director of Care and the Resident Service Coordinator investigated resident #009's and his/her family's concerns.

The licensee's investigation included statement from PSW #110, Registered Practical Nurse #105, and the CallPoint by Location Activity Report.

Executive Director indicated, to the inspector, that the investigation identified that Registered Practical Nurse #105 was on his/her break at the time of the incident and was not notified that resident #009 was having difficulty. Executive Director further indicated that the Registered Nurse working within the long-term care home, was not notified of the resident's complaints by the PSW.

Executive Director indicated that the licensee's investigation concluded, and it was determined that PSW #110 did not respond to resident #009's care needs in a timely manner, and did not seek assistance when resident #009 complained of having the identified difficulties.

Registered Practical Nurse #105, and PSW #110 failed to ensure that the plan of care was provided to resident #009 as specified in the plan, specifically failed to promptly provide assistance or seek assistance from Registered Nurse-Charge Nurse when resident was complaining of identified symptoms. [s. 6. (2)]

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

Related to Intake #009088-17:

The Associate Director of Care (ADOC) submitted a Critical Incident Report (CIR) to the Director on an identified date, regarding an alleged incident of staff to resident abuse. The CIR provides details, indicating that resident #007 expressed to his/her family and the charge nurse, a day earlier, that personal support worker (PSW) #106 had allegedly reprimanded him/her (the resident) for soiling the bed.

Resident #007 is cognitively well. Resident #007 has a history which includes, physical impairment; resident is dependent on staff for all activities of daily living.

The clinical health record, for resident #007, was reviewed by the inspector the following is documented:

Written Care Plan (identified review date):

- Toileting – Interventions include, resident is on a scheduled toileting program at identified hours on an identified shift; to be offered a bedpan at identified times. Goal of care is indicated as resident will be clean, dry and odour free.
- Transfers – Interventions include, uses mechanical lift, two staff required to transfer resident safely; resident is not able to assist.
- Impaired Hearing – Interventions include, resident has bilateral assistive devices; resident requires staff to place the assistive devices in daily; staff to ensure you have residents attention before beginning to speak.

Progress Notes (period identified):

- On an identified date – Resident #007 came to the dining room, appearing upset. When Registered Practical Nurse (RPN) asked resident what was wrong, resident did not respond. RPN indicated in his/her documentation that resident #007 was late getting to the dining room, due to PSW's getting resident up later than usual. RPN asked a PSW why resident was upset, PSW indicated resident #007 was upset, as his/her bed was soiled. Later that shift, RPN documented that resident #007's family voiced concern, via telephone, that resident #007 was upset as a PSW had allegedly reprimanded him/her (the resident) for soiling the bed. Family indicated his/her displeasure and indicated that he/she would be contacting the Office Manager to voice his/her concern, as to the incident.

The alleged abuse incident, involving resident #007, was investigated by the Associate Director of Care (ADOC) and Executive Director. The licensee's investigational notes

were provided to the inspector, and contained statements taken from PSW #106, and resident #007.

Personal Support Worker indicated in his/her statement that he/she and co-worker did not arrive to provide care to resident #007 until an identified hour. PSW #106 indicated in the statement that resident #007 expressed to him/her (PSW #106) that the bed was soiled; PSW #106 indicated to resident #007, that he/she should have used the call bell for assistance. PSW denied raising his/her voice or speaking to the resident in an angry tone. PSW #106 indicated resident may have misinterpreted the conversation, as resident was not wearing his/her assistive devices at the time that care was being provided.

Personal Support Worker #106 was unavailable for an interview.

Resident #007 refused to comment on the above incident.

Associate Director of Care and Executive Director indicated, to the inspector, that the licensee's investigation concluded and it was determined that the care was not provided to resident #007 as follows:

- PSWs did not arrive to provide care to resident until an identified hour, resident is to be toileted approximately an hour earlier as per the planned toileting schedule;
- PSW did not provide resident with his/her assistive devices prior to commencing care or communicating with resident #007.

The licensee failed to ensure that the care set out in the plan of care was provided, to resident #007, as specified in the plan, specific to toileting and assistance with aides of daily living/assistive devices. [s. 6. (7)]

4. Related to Intake #005010-17:

The Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of staff to resident abuse/neglect, involving resident #011.

Resident #011 has a history which includes physical impairment. Resident is dependent on staff for activities of daily living.

The clinical health record, for resident #011, was reviewed by the inspector with the following details documented:

Written Care Plan (identified date):
- Toileting – resident is unable to complete task alone, due to physical limitations. Interventions include, staff to complete full toileting needs; uses an identified lift to transfer on/off toilet and commode.
- Transfers – resident is unable to complete task alone. Interventions include, uses identified lift with two staff for all transfers.
Continence Assessment:
- Urinary Continence Assessment was completed on an identified date, by registered nursing staff. Resident #011's abilities are indicated as, the resident can ask for assistance, and is motivated to be continent. Resident #011 requires the assistance of staff for toileting due to impaired mobility.

The alleged abuse incident was investigated, by the Associate Director of Care, Associate Director of Care and the Executive Director. The investigation included interviews of Resident #011, Personal Support Workers, and Registered Nursing Staff; it was determined that the incident occurred on an identified date, during identified hours, and involved concerns surrounding continence care and management. The investigation, by the licensee, included a review of the CallPoint Detailed Activity Report by Location, which is a detailed report of the communication and response system (call bells) for identified resident rooms, activation times and duration of calls for assistance.

Statements, by resident #011 and nursing staff are documented as follows:

- Resident #011 indicated, in his/her statement to the Director of Care (DOC), that he/she rang her call bell (on the identified date), as he/she needed to use the washroom, resident indicated that PSW #113 responded to the call bell, resident #011 indicated he/she told PSW #113 that he/she needed to use the washroom and needed to be put onto the toilet, PSW responded you will have to wait, there is only one staff on the unit; PSW left the room. Resident stated to DOC that he/she called SDM (substitute decision maker) telling his/her SDM that he/she needed to use the washroom. Resident #011 indicated ringing the call bell again, indicating PSW #113 responded to the callbell, but by the time staff arrived he/she had been incontinent. Resident indicated ringing the call bell at other times that evening without staff responding.

- Personal Support Worker #113 indicated, in his/her statement to the Director of Care,

that resident #011 rang the call bell, on the identified date, stating he/she needed to use the washroom. PSW #113 indicated telling resident he/she had to wait as he/she was the only staff on the unit, PSW indicated he/she left resident's room. PSW indicated that resident #011 rang his/her call bell again, and by the time he/she responded resident #011 had been incontinent.

- Registered Practical Nurse #105, who was the assigned Charge Nurse, on another resident home area indicated, in his/her statement to the Director of Care that he/she had received a phone call from the SDM of resident #011 on the identified date, RPN #105 indicated that the SDM had called to say that resident #011 had to use the washroom, and staff had not been responding to the call bell. RPN #105 indicated, in his/her statement, that he/she asked PSW #108 to go to the resident home area, where resident #011 resided, to notify staff that resident #011 needed to use the washroom.

- Personal Support Worker #108 indicated, in his/her statement to the Director of Care, that he/she was directed by RPN #105 to go to resident home area to notify staff of resident's need to use the washroom. PSW #108 indicated in his/her statement that he/she arrived on the resident home area and found resident #011's call bell ringing, he/she entered resident #011's room, turned off the call bell and asked resident what he/she needed, resident indicated needing to use the washroom. PSW indicated telling resident that he/she would get him/her assistance. PSW #108 indicated that PSW #114 was in hallway, same area resident #011 resides, doing the nourishment cart. PSW #108 indicated PSW #114 indicated to him/her "resident #011 will have to wait, all he/she ever does is call for the bathroom." PSW indicated at that time, he/she left the resident home area and went back to his/her own unit. PSW reported to RPN #105 that he/she had communicated the care needs of resident #011 to staff.

- Personal Support Worker #114 indicated, in his/her statement to the Director of Care, that PSW #113 had indicated that resident #011 had rang the call bell, but by the time he/she (PSW #113) arrived resident had been incontinent. PSW #114 indicated the statement to the DOC, that at some point during the same shift, PSW #108 approached him/her stating that resident #011's SDM had called, indicating that resident #011 needed care (to be changed). In a later statement (different date), PSW #114 indicated to DOC that he/she recalled PSW #108 coming over to the resident home area, indicating that resident #011 was ringing his/her call bell and needed to use the washroom; PSW #114 indicated he/she recalls telling PSW #108 that he/she would get to resident #011 after he/she was done doing the nourishment cart.

CallPoint Detailed Activity Report by Location, for the identified date, resident #011's room:
- At 1909 hours, the call bell was activated;
- At 1936 hours, the call bell was activated;
- At 1955 hours, the call bell was activated;
- At 2028 hours, the call bell was activated;
- At 2103 hours, the call bell was activated;
- At 2126 hours, the call bell was activated.

Resident #011 indicated, to the inspector, that he/she recalls incidents where staff have not responded to his/her requests to be toileted promptly and such has resulted in his/her being incontinent. Resident believes that on the date in question, he/she rang several times to use the washroom, and that staff responding to his/her call bell indicated that the staff were off the unit and he'd/she'd have to wait.

The Associate Director of Care and The Executive Director indicated, to the inspector, that it would be an expectation that call bells are promptly responded to and that residents are toileted upon request.

The Executive Director indicated that the licensee investigation was completed, and it was concluded that resident #011’s complaint was valid, indicating that the PSW failed to answer a resident’s call bell and failed to assist with toileting of resident #011.

Personal Support Worker #114 failed to ensure that the care set out in the plan of care, for resident #011, was provided as specified in the plan. [s. 6. (7)]

5. Related to Intake #014107-17:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, on and identified date, regarding an alleged incident of resident to resident sexual abuse. The incident occurred on six days earlier, was witnessed by a visitor, and involved residents #004 and #006.

Resident #004 has a history including cognitive impairment. Resident #004 is ambulatory. Resident #004 exhibits identified responsive behaviours.

Personal Support Workers, Registered Practical Nurse (RPN) #102, Associate Director of Care (ADOC) and the Executive Director indicated, to the inspector, that resident #004 is

known to exhibit identified responsive behaviours towards both residents and staff, of a specific gender. RPN #102, ADOC and the Executive Director indicated that the planned care for resident #004 included 1:1 staffing.

Registered Practical Nurse #102 indicated, to the inspector, that resident #004 has had at least four incidents (prior to the identified date), where he/she exhibited similar responsive behaviours.

Registered Practical Nurse #102, ADOC, and the Executive Director indicated, to the inspector, that 1:1 staffing, for resident #004, was initiated to monitor the responsive behaviours of resident #004, while ensuring the safety of other residents, from resident #004.

Registered Practical Nurse #102, as well as the ADOC and Executive Director all indicated, to the inspector, that staff are expected to follow the planned care for each resident.

The clinical health record, for resident #004, was reviewed, by the inspector, with the following documented:

Written Care Plan (identified review date):

- Responsive Behaviours – identified specific behaviours exhibited; Interventions include, referrals and consultation with Psycho-Geriatric Outreach; sensor alarm (on door, resident room) to monitor resident's movement; 1:1 staffing for safety of others.

Progress Notes:

- On an identified date– identified shift; No 1:1 staffing available. Resident continues to pace hallways, uttering comments of a sexual nature.
- One day later – 1:1 staffing will remain in place during identified hours. At an identified hour, registered nurse documents, that there was no 1:1 staffing available this shift. Resident continues to wander on and off the resident home area, heard making comments of a sexual nature; comments offensive to other residents. Resident #004 difficult to redirect.
- Two days later – Continue with 1:1 staffing as ordered by Physician.
- Eight days later – At an identified hour, Resident #004 heard being sexually expressive with staff. Resident became agitated with staff, when staff attempted to redirect thoughts

and comments.
- Five Days later – Visitor reported to Registered Nurse that last week, on an identified date during an identified shift, resident #004 was witnessed (by visitor) inappropriately touching resident #006.
Visitor indicated he/she was unable to locate staff at the time of the incident, and left the long-term care home without reporting what he/she had witnessed.

The Executive Director indicated, being aware, after the fact, that there was no assigned 1:1 staff two identified dates, indicating, to the inspector, that he/she has spoken with the Scheduling Clerk regarding the importance of contacting herself (Executive Director) and or the Director of Care if the 1:1 shifts cannot be filled/covered.

Resident Service Coordinator (RSC) provided the inspector with a copy of the staffing schedule for an identified shift. The staffing schedule indicates that on the identified shift during the identified shift there was no assigned staff to cover the 1:1 staff for resident #004. Resident Services Coordinator indicated to the inspector that there was no 1:1 assigned on the indicated shift.

The Associate Director of Care and the Executive Director indicated that on identified shift, there was no 1:1 staffing present with resident #004 was observed inappropriately touching resident #004.

On an identified date, following the submitted CIR (above) resident #004's plan of care was reviewed and revised to include 24 hour 1:1 staffing. At the time of this inspection, 1:1 staffing remained in effect for resident #004.

On an identified date during this inspection, resident #004 was observed, by the inspector, with no 1:1 staffing in attendance. Personal Support Worker (PSW) #112 was observed, by the inspector, exiting another resident's room down the hallway; PSW #112 indicated, to the inspector, that resident #004 was to have 1:1 staffing in place at all times, and indicated it was his/her belief that resident #004's assigned 1:1 staffing must have left his/her assignment to use the washroom. PSW #112 indicated he/she was unsure who was covering the assigned 1:1 PSW while absent; PSW #112 continued down the hall. Approximately nine minutes later, PSW #121 came around the corner towards resident #004's room indicating, to the inspector, that he/she was the assigned 1:1 staff and had left to use the washroom.

Personal Support Worker #121 indicated, to the inspector, that he/she had been directed

by the Executive Director that resident's assigned as 1:1 were not to be left unattended, and that prior to leaving for breaks, ect, 1:1 staffing are to ensure they have a replacement. PSW #121 indicated that he/she had not replaced him/herself prior to leaving his/her assignment to use the washroom. PSW #121 indicated that it was his/her belief that resident would be fine as he/she was asleep in his/her room.

Registered Nurse (RN), who was the designated Charge Nurse, assigned to the resident home area, indicated, to the inspector, that he/she was not aware that PSW #121 had left the assignment without coverage. RN indicated resident #004 was to have a staff with him/her at all times, to ensure other resident's safety.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #004, as specified in the plan, specifically 1:1 staffing, during identified dates which placed other residents at risk. [s. 6. (7)]

6. Related to Intake #011714-17:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an alleged incident of resident to resident sexual abuse. The incident involved residents #002 and #005.

Resident #002 was admitted to the long-term care home on an identified date, and has a history which includes, cognitive impairment. Resident #002 is ambulatory. Resident #002 exhibits identified responsive behaviours.

Personal Support Workers, Registered Practical Nurse (RPN) #102, Associate Director of Care (ADOC) and the Executive Director indicated, to the inspector, that resident #002 is known to exhibit identified responsive behaviours towards residents and staff of a specific gender. RPN #102, ADOC and the Executive Director indicated that the planned care for resident #002 included 1:1 staffing.

Registered Practical Nurse #102, who is the co-lead for the BSO Team (Behaviour Supports) at the long-term care home, as well as the ADOC and Executive Director all indicated, to the inspector, that staff are expected to follow the planned care for each resident.

The clinical health record, for resident #002, was reviewed, by the inspector, with the following documented:

Written Care Plan (currently in place):

- Responsive Behaviours – identified behaviours; Interventions include, distract resident using puzzles and or music; discourage inappropriate expression by setting boundaries call resident by name; if continues to make inappropriate comments, leave in a safe place and reapproach; 1:1 staffing initiated on a specific date; referrals and consultation with Psycho-Geriatric Outreach; notify physician of changes in behavioural status.

Progress Notes:

- On an identified date– At an identified time, staff heard a resident screaming, went down hall to investigate and found resident #002 in resident #005's bed. Resident #002 was unclothed from the waist down, lying in bed with resident #005. Resident #005 was screaming for help. Staff were unable to redirect resident #002, and intern removed resident #005 from the room and provided reassurance. On-Call Manager notified; police contacted for assistance. Resident #005 sustained no physical injuries. Physician's orders received, specific to medication changes, referral to psycho-geriatric outreach and 1:1 staffing, for resident #002, increased from a specific shift to 24 hours, to ensure safety of other residents.

Associate Director of Care and the Executive Director indicated, to the inspector, that resident #002's planned care included 1:1 staffing during the identified hours. Executive Director indicated, to the inspector, that an investigation was initiated questioning how the incident between resident #002 and #005 occurred, when there was to have been an assigned Personal Support Worker (PSW) on the identified shift. Executive Director indicated, to the inspector, that the investigation concluded, and found that Personal Support Worker (PSW) #121, who was the assigned 1:1, had left resident #002 unattended to assist a colleague down the hallway, and while assisting the colleague with another resident, they (the PSWs) heard resident #005 screaming for help, and found resident #002 in bed with resident #005.

Personal Support Worker #121 indicated, to the inspector, being aware of the planned care for resident #002, but indicated that another PSW needed assistance, and he/she had left resident #002 in his/her room asleep.

The Associate Director of Care and the Executive Director indicated, PSW #121 left his/her 1:1 staffing assignment, leaving resident #002 unattended, resulting in resident

#002 being found in bed with resident #005. [s. 6. (7)]

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 there is a process in place and monitored, ensuring that the written care plan for each resident sets out the planned care for the resident; that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident; and that the care set out in the plan of care was provided the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee's policy, 'Operation of Mechanical Lifting/Transferring and Repositioning Devices' (#CARE-O10.07) states that prevention of employee and or resident injury is a key strategy in licensee's Safe Ambulation, Lifts and Transfers (S.A.L.T) Program. Licensee has a zero tolerance for improper resident/client manoeuvring. Any activity of non-compliance regarding resident/client manoeuvring will not be tolerated. The policy, 'Operation of Mechanical Lifting/Transferring and Repositioning Devices' directs that all staff shall use supplied mechanical lifting and transferring devices to assist with lifting/transferring or repositioning residents as documented within each resident plan of care. Two staff must be present at all times while the mechanical device is in operation.

The licensee's policy, 'No Manual Lift Directive' (#CARE6-O10.06) directs that staff will use, a mechanical lifting/transferring device for every resident, who can not weight bear or exhibits high risk characteristics as concluded by the lift and transfer assessment. The

use of the lifting/transferring device will be identified in each resident's profile/care plan/ADL sheet.

Personal Support Worker (PSW) #103 and Registered Practical Nurse (RPN) #102 indicated to the inspector that two staff are required whenever a mechanical lift is in use, and indicated that long-term care home has a no (manual) lift policy.

Resident Services Coordinator/Staff Educator (RSC) indicated to the inspector that all nursing staff have been provided annual inservices related to Falls Prevention and Management, which includes the S.A.L.T program. RSC provided, the inspector, with the SURGE Learning (electronic staff education) for 2016, the document provided supports that, all nursing staff, including PSW #103, received the S.A.L.T program training on an identified date in 2016.

Related to intake #010163-17

The Associate Director of Care submitted a Critical Incident Report (CIR) to the Director, on an identified date, regarding an allegation of neglect of care, involving resident #010. The substitute decision maker (SDM) alleges that the injury sustained by resident #010, two days earlier, resulted from staff neglect.

Resident #010 has a diagnosis which includes cognitive impairment. Resident is dependent on staff for activities of daily living (ADL), and has been identified as being at risk for falls.

The clinical health record, for resident #010, was reviewed by the inspector, for an identified period, documentation details the following:

Written Care Plan (identified date):
- Transfers – resident is dependent on staff, falls risk identified. Goals of care include, resident to experience a comfortable and safe transfer. Interventions include, use of a mechanical lift with 2 staff for all transfers.
- Skin Integrity – resident has fragile skin.

S.A.L.T Assessment (identified date):
- Mechanical Lift - 2 staff members required, Passive Floor Lift or Ceiling Lift - all shifts

Progress Notes:

- On an identified date – Resident was assessed by nursing staff to have an identified injury. Origin of the injury was unknown. Substitute Decision Maker notified of the injury by registered nursing staff. SDM voiced concerns regarding care and the injury.

The Associate Director of Care (ADOC), and the Executive Director initiated an investigation into the concerns of resident #010's SDM.

The Executive Director indicated that the investigation included interviews with personal support workers and registered nursing staff, who worked the day and evening shift on the identified date. Executive Director indicated the investigation was completed, and concluded that Personal Support Worker (PSW) #103 manually transferred resident into his/her wheelchair, without the required mechanical lift device and a second staff.

Personal Support Worker #103 indicated, in his/her statement to the Executive Director, that he/she did not use the mechanical lift while transferring resident #010, as the resident was 'scared' of the lift. Personal Support Worker #103 indicated, to the inspector, that he/she was aware of the care needs, which included use of transferring and lifting devices.

A letter, identified date, was issued to PSW #103, by the Executive Director indicating that PSW failed to follow the planned care interventions for resident #010, and indicated, in the letter, that PSW #103 placed resident #010 at risk.

Personal Support Worker #103 failed to ensure that safe transfer and positioning devices or techniques where used when assisting resident #010. [s. 36.]

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 there was a process in place and monitored, ensuring staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 failed to ensure that supplies, equipment and devices related to the home 's resident-staff communication and response system is readily available to meet the nursing and personal care needs of residents.

The licensee's policy, 'Maintaining a Safe and Secure Environment' (#ADMIN10-P10) indicates that licensee strives to maintain a safe, respectful environment for residents safety and quality of life. The policy directs that medical devices and equipment used in the treatment and healthcare of residents are maintained in a good state of repair, which is said to include, communication and response system (call bells).

Related to Intakes #014152-17 and #013200-17:

The Director of Care submitted two separate Critical Incident Reports (CIR) to the Director regarding alleged staff to resident abuse/neglect. During the investigation, of each of these incidents, it was found that there had been delays in staff response to residents call bells, which subsequently resulted in a residents care needs not being met in an timely manner. (reference WN #1 and WN #4)

The long-term care home, is a two storey building, which has four resident home areas, with four Personal Support Workers and a Registered Nursing Staff assigned to work on each resident home area on both days and evenings; the number of staff decreases during the night shift.

The licensee's communication and response system (the system) is designed to use pagers to notify personal support workers when residents (or others) activate the system, by pulling/pressing the call bell. As per the Resident Service Coordinator and the Associate Director of Care, each PSW is to carry a pager at all times to identify and respond to resident care needs. Registered Nursing Staff also had phones that were activated (audible alarm) five (5) minutes after a call bell was activated if not responded

to by PSWs.

Personal Support Workers (PSW) #112 and #120, Registered Nursing Staff #102 and #111, the Resident Service Coordinator and the Associate Director of Care all indicated to the inspector that the long-term care home has not had pagers available for use for approximately two (2) years. All cited the reason that pagers were not available was that the pagers were broken, that there were frequently no batteries available for the pagers, staff were taking the pagers home, and or pagers were generally missing. PSW #112, and RPN #111 indicated, to the inspector, that the pagers, which had been in use, had both an audible alarm and a visual screen to alert staff that a resident needed assistance. Registered Practical Nurse #111 and Resident Service Coordinator indicated that portable phones carried by registered nursing staff no longer receive alerts for call bells, as the long-term care home's phone system was changed and it (the phones) no longer have a call bell feature attached. RPN #111 and RSC indicated the phone system changed about a year ago. Staff interviewed indicated that the Director of Care, and the Executive Director (past and present) were aware that PSWs no longer had pagers available for use.

The Environmental Services Manager (ESM) indicated, to the inspector, that he/she has been employed as a contracted worker since January 2017. ESM indicated being first aware that staff were not carrying pagers in May 2017 by the current Executive Director, stating that he/she had not been informed that the pagers were broken and or in need of batteries. ESM indicated the portable phone system had changed prior to his/her employment, in the long-term care home.

The Executive Director indicated, to the inspector, that he/she was first aware that there was issues with the communication and response system, in approximately May 2017, while investigating a complaint from a resident and family regarding lack of response by staff to call bells.

The Executive Director indicated communicating concerns surrounding the communication and response system (pagers and portable phones) to the licensee. The Executive Director indicated he/she and the maintenance department have been in contact with a system provider to get new system pagers implemented and other system upgrades. Executive Director indicated the quote for the system upgrades had been received and forwarded to the licensee for approval, and that the CEA (capital expense approval) had been approved by the licensee on an identified date.

Executive Director indicated that he/she was rolling out the ' new system pagers' as of mid-day August 10, 2017, and that the system upgrades would continue. [s. 44.]

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 there is a process in place and monitored, ensuring supplies, equipment and devices related to the home's resident-staff communication and response system is readily available to meet the nursing and personal care needs of residents, to be implemented voluntarily.

Issued on this 1st day of September, 2017

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

Original report signed by the inspector.